IN THE SURREY CORONER'S COURT

IN THE MATTER OF: Melanie Jane ELMS

The Inquest Touching the Death of Melanie Jane ELMS

A Regulation 28 Report – Action to Prevent Future Deaths

	• **SABP**
1	**CORONER** J. Russell-Mitra HM Assistant Coroner, for the County of Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** An inquest into the death of Melanie Jane Elms was concluded on 15th April 2021. I found that the cause of death was: I a Blunt chest and abdominal trauma

	I concluded with a narrative conclusion as follows: Melanie Jane Elms was an informal patient at the Abraham Cowley Unit and had a history of schizo-affective disorder and of suicidal attempts. On 30th January 2018 she requested day leave from the unit for part of the day. A mandatory risk assessment which should have been undertaken by a nurse before Melanie left the unit was not carried out and consequently she was permitted to leave the unit without her mental state be assessed and therefore was unclear. There was a failure by the Unit to record, consider and thereafter act upon concerns made to it by her husband regarding Melanie's welfare during the day. At about 20.37, Melanie entered [redacted] After a short period spent on the [redacted] whereupon she deliberately [redacted]. As a result she suffered fatal injuries that led to her death .Whilst her intention at the time of the event is unclear her mental health condition materially contributed to her death. I adjourned consideration of whether to write a report for the prevention of future deaths for further evidence to be provided.
4	**CIRCUMSTANCES OF THE DEATH** i.) Melanie struggled with significant mental health problems including schizo-affective disorder, alcohol addiction, depression and severe post-natal depression. Melanie had several admissions under the Mental Health Act 1983. She was married with one son. ii.) On 21st July 2017 she was discharged from a two and a half year admission under the Mental Health Act 1983. Between 21st July and 24th July 2017 she was discharged to a crisis house. iii.) Her treating doctor had created a care package to allow Melanie to cope in the community. It included carers visiting Melanie every day. However, until they were able to start a short term arrangement was made. The proper package of care was never put in place. iv.) Between July 2017 and December 2017 Melanie and her family struggled with her return to the community and the limited package of care. v.) Her husband struggled to support Melanie on the limited package of care she was receiving. He made numerous calls to CMHRS asking for more support and more care particularly because Children Services' concerns remained. vi.) On 2nd October after Melanie had been assessed by the HTT having

committed self-harm with suicidal intentions which she later denied, she was found a crisis house and Martyn asked for her to be allowed to stay longer but was told no. On 26th October Melanie with some insight asked to return to the crisis house.

vii.) As things unravelled for Melanie, on 9th December 2017 her husband and son returned to the family home to find it filled with black smoke. Fire services attended and found Melanie asleep upstairs and refusing to leave. She was responsible for starting the fire by putting cigarettes into the sink pipes. It is not clear if she knew what she was doing.

viii.) As a result of this incident, Melanie was admitted to Blake Ward, ACU as an informal patient.

ix.) Due to the seriousness of the incidents in the family home some of which were in front of her son, and that the final incident had rendered the family home unliveable until made safe and refurbished, Children's Services required stronger measures in place to protect [redacted]. These included a Non-Molestation Order and Occupation Order.

x.) On 22nd December 2017 Melanie's treating doctor was changed to someone who did not have a detailed knowledge of her last admission.

xi.) As an informal patient, Melanie was allowed leave unrestricted. There seemed from the evidence at that time to be a culture that informal patients were not challenged about leave and therefore although there were some checks that were in place were not being performed as rigorously as they could have been. The "walk book" the record of those on leave from the ward is a sparse document and no recording of risk is made on the face of it. This along with a number of other things has been changed subsequent to Melanie's death.

xii.) On 15th December Melanie had leave and she had been expected back at 18.25. By 2200 the ward staff started to call Melanie's phone and her husband's phone. Her husband had not been notified of her leave. She was found at 2300 to have returned to the fire-damaged home address intoxicated and distressed and she reported to her husband that she was having a miscarriage and was bleeding. Ambulance and police attended and Melanie was found to have wound. Melanie was returned via A&E to Blake Ward. There were reports that she had smashed things in the house. Melanie was not pregnant and had not been.

xiii.) Between the 16th and 19th December nurses were concerned she would abscond and used their temporary holding powers to stop her

leaving.

xiv.) On 19th December she used her leave at around 1330. The ward received a telephone call that Melanie was in the local pub and was behaving bizarrely. Staff had to retrieve her from the pub.

xv.) She had leave between 22nd and 24th December without incident.

xvi.) On 29th December Melanie used leave and did not return on time, concerns were raised at 2200 and she was classified as a missing person. The ward received a telephone call from A&E where Melanie had gone because she was concerned she was having a miscarriage. Melanie was not pregnant and had not been.

xvii.) Melanie had two further periods of leave which went without incident.

xviii.) On 10th Jan 2018 – a Child Protection Meeting about her son was convened and Melanie did not attend but was very distressed and angry about it. She used leave at 1300 and stayed out half an hour beyond the expected time intoxicated.

xix.) On 13th January she used leave for an hour without any incidents On 16th January 2018- she used leave and called the ward to say she would be late. She had attended the temporary accommodation where her family were staying.. Melanie was alleged to have broken glass and assaulted police officers and she was taken into police custody. Melanie was bailed and returned to the ward on 17th.

xx.)On 19th January and 21st January – she used leave without incident. On 22 January Melanie went out early and did not return until 2100. On 23rd January she went out several times, no issues On 25th January- Melanie went on leave and returned smelling of alcohol and was abusive to staff

xxi.) On26th January- her husband called the ward because Melanie was expressing suicidal intetions. On 27 January- although described as agitated and erratc, she used leave without issues On 28th January- she used leave and was irritable and aggressive on return. On 29 January she used leave no issues

xxii.) On one of the leaves, not clear which one, Melanie was wandering in Ottershaw and was found in the dark by a mechanic who helped her to return to the ward.

xxiii.) On 30th January 2018 Melanie was RAG rated green. This has been explained as a traffic light system of risk which is given to each patient daily. The ward was very busy and her allocated nurse was

unable to go through Melanie's care plan with her. The ward was also reliant on agency nurses: they were qualified to do the work but were not allowed access to the computer recording system for putting notes onto the system.

xxiv.) Melanie went on leave at some point during the day shift. The only recording of this in the notes is retrospectively. The walk book which is a handwritten document filled in by the nurse who is signing any person out of the ward and which should include details of when the person is expected back and what they were wearing so that a missing person report can be filed with the police if any when necessary.

xxv.) However, on the 30th January 2018 no risk assessment was undertaken of Melanie before she left the ward. There is no walk book for her and no trace of the nurse who granted her leave on that day.

xxvi.) What is known about 30th January 2018: Melanie went to the Sainsburys in Chertsey and rang her husband to tell him that she couldn't get back to the ward and that she felt weird. She did not describe or explain how. It was unclear why she couldn't get back as it was a short walk away. She was asking to be picked up. Her husband was not able to pick her up due to commitments to their son and because of how he had been advised to handle Melanie's requests. This was at about 16.30.

xxvii.) Melanie's husband called the ward just after this call. The Systemone notes written retrospectively on 31st refer to a call at 20.30 from her husband. An agency nurse took the call but the notes about it were entered by the allocated nurse from what she had overheard.

xxviii.) Melanie's husband called again around 20.00 and this is supported by the retrospective entry although that is timed as being at 20.30 but is not a contemporaneous record. By this time the night shift staff were on duty and Melanie had still not returned. Her husband was concerned that she had been a short walk away from the facility at 16.30 wanting to return and 3 1/2 hours later had not returned.

xxix.) At about 20.00 her husband received a telephone call from his local gym where both he and Melanie were regular members. Melanie had asked the gym to use the phone and she had called Melanie's husband. Melanie said she was trying to find her mum and couldn't find her. Melanie's mum lived in a house in Thames Ditton. Melanie's husband tried to ascertain if Melanie had been drinking and where she had been since her last call. She became impatient and

handed the phone back to the gym receptionist who stated that Melanie was saying she was going to get a taxi and no longer wanted a lift. Melanie's husband telephoned the ward again to say where she was and what had happened.

xxx.) Melanie's husband was concerned about Melanie and thought given the mention of her mum that Melanie might have been at her mum's. He called her mum but Melanie was not there and had not been in touch and her mum was angry and refused to go to the end of the road to look for Melanie.

xxxi.) Melanie's mum told her son who lived with her about the call and they made a plan with Melanie's husband about where to search for her and began looking for her.

xxxii.) A train driver was driving the 20.54 Hampton Court to Waterloo train with headcode [redacted] and it had left Hampton Court station to begin its journey. It was clear dark dry evening. The train had conducted a running brake test just after leaving Hamptin Court station. The journey between Hampton Court station and Thames Ditton Station was about two minutes. The train had not yet reached the far end of the station platform known as the country end so no part of the train was yet adjacent to the platform. The train driver described seeing a woman [redacted] As soon as he saw her he applied the emergency brakes. [redacted]

xxxiii.) There was not enough time for the train to stop. The train struck the woman, who was later identified via fingerprints as Melanie, and her body came to rest under the second or third carriage of the train. ROLE was declared at 21.30 by a paramedic.

xxxiv.) Among her belongings some notes were found that seem to be addressed to her son. These notes do not look as if they were written all at the same time. They cannot be classified as suicide notes and do not disclose an intention to commit suicide. They do show a distressed state of mind.

xxxv.) From what can be ascertained from toxicology results she had in her system some of her therapeutic medications at a therapeutic dose. She also had a blood alcohol of 68 ml/dL this is a low concentration and she would not have been likely to have been intoxicated on this concentration, particularly given her tolerance to alcohol. However, the

	toxicologist is also unable to say if there had been an excess ingestion of drugs due to the effect of rapid death. There is no evidence that Melanie was under the influence of drugs or that she had ingested a larger quantity than her usual therapeutic dose as dispensed at the ACU.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. The care package arranged for Melanie following discharge from lengthy in-patient admission was not followed and was altered to something which the treating doctor did not consider adequate. 2. The walk book was not properly completed. 3. There was no extra planning for changes in circumstances: Melanie faced never being allowed to return to family life with her husband and son due to Child In Need proceedings; changes in medication and less support from family due to the Social Services requirements. 4. There was no missing person plan in place with timeframe and steps of escalation for Melanie's leave. 5. Risk assessment prior to leave was not adequate. 6. Risk assessment prior to leave was not recorded.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; [redacted]. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Signed:** **J. Russell-Mitra** **Dated this 7th March 2022.**