	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sheffield Health and Social Care Trust** **2. Ministry of Justice**
1	**CORONER** I am Abigail Combes, assistant coroner, for the coroner area of South Yorkshire (West District)
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** On 9 September 2020 I commenced an investigation into the death of Marjorie Grayson born on 4 March 1935. The investigation concluded at the end of the inquest which commenced on 27 January 2022. The conclusion of the inquest was:- On the 3 September 2020 Marjorie Grayson [redacted] at her property [redacted] Sheffield resulting in her death. At the time of her death she was in contact with Mental Health services and had been identified as low risk of causing harm to herself. She [redacted] with the intention of effecting her death and knowing this was very likely to be the result. And the conclusion recorded was suicide. The medical cause of death was: 1a: Blunt force head trauma
4	**CIRCUMSTANCES OF THE DEATH** Following the hearing of evidence I made the following findings:- 1. On 13 September 2018 Marjorie Grayson stabbed her husband four times resulting in his death 2. She contacted emergency services and was subsequently arrested for his murder 3. Prior to this incident their marriage had been content and loving and Marjorie had no significant documented mental health problems. 4. Marjorie was initially remanded in prison where it is documented she had 'dark thoughts' and feelings of guilt and a desire to be with her husband. She also expressed a view that she deserved to die for what she had done but denied intending to end her life 5. There were a number of incidents in prison which resulted in her being closely observed and her risk levels being relatively frequently reviewed 6. Ultimately she was assessed by psychiatrists and pleaded guilty to her husband's manslaughter with a working diagnosis of dementia being the explanation for her offence

7. Following her conviction she was moved to St Andrew's Healthcare in Northampton detained under s37 of the Mental Health Act. The Hospital Order was made on 28 June 2019.

8. At St Andrew's an MRI scan was undertaken which did not provide for a definite diagnosis and a functional MRI scan was planned. Psychological therapies were also commenced and Marjorie seemed to be doing well with these.

9. On 10 October 2019 plans were put in place for Marjorie to be moved to Grenoside Grange from St Andrew's. This was described by Dr [redacted] as a quick decision which she had not anticipated. Dr [redacted] also explained that she anticipated Marjorie would be with her for a significant period of time; at least months.

10. On 25 October 2019 Marjorie was moved to Grenoside Grange and the team there took over responsibility for her care. She appeared settled on moving and as a result she was detained from her section in December 2019. This was without a firm diagnosis.

11. Dr [redacted] was clear in her evidence that she would not have discharged Marjorie without a clear diagnosis as that would be required to assess risk.

12. Planning to discharge Marjorie from hospital on the evidence of Dr [redacted] commenced in February 2020 and from [redacted] it was January 2020.

13. Grenoside Grange did not offer a functional MRI as they did not have the equipment available to do this.

14. Grenoside Grange also did not offer psychological therapy to Marjorie as they felt that there was a risk this would make things worse and not better and could cause more risk. To be clear, on the basis of the evidence which I have heard, this therapy had commenced at St Andrew's and therefore the decision at Grenoside Grange was not to not offer the therapy but it was a decision to stop a therapy that had already been commenced. I do not believe there was adequate consideration or risk assessment of this decision however I cannot say whether this contributed to the outcome for Marjorie.

15. Throughout Marjorie's time in hospital she continued to describe dark thoughts and concerns about guilt and how her family could continue to support her. Non the less the team at Grenoside did not believe that she posed a risk of harming herself or others and the plan to discharge her was effected in March 2020.

16. At the point of Marjorie's discharge home a diagnosis of mild cognitive impairment had been established. This did not account for the index offence or Marjorie's evident lack of impulse control.

17. On the basis of the evidence I have heard there were two documented episodes of poor impulse control that Marjorie demonstrated; whilst low in frequency it is clear that in terms of severity these episodes were of the highest level. This does not appear to have been considered by the team at Grenoside Grange or informed risk planning.

18. Marjorie was discharged into the care of her family. This was in part because of Covid-19 and in part as a result of the assessment that she was ready for discharge. The impact of Covid-19 however was that her Home Treatment Team input would be remote. I can find no evidence of a clear risk assessment balancing the risk of exposure to Covid-19 for Marjorie against the risk of not physically seeing her upon discharge. Had this been done it may be that factors such as Marjorie being discharged to the care of her family whom she had expressed feeling guilty about; the plan to discharge her to her home address which was the scene of the index offence; and the plan to discharge her to her

family who were given little or no support in looking after Marjorie; ought to have been features which weighed heavily in favour of seeing Marjorie face to face.

19. In any event Marjorie was only spoken to on the phone on two occasions during the two to three weeks under the care of the Home Treatment Team. Given the circumstances of Marjorie's case this does not, on the basis of the evidence, appear adequate to manage the risk.

20. Marjorie was subsequently discharged to the community team and given support that would be available to anyone in the community suffering with mild cognitive impairment. It appears, on the basis of the evidence, that the team supporting Marjorie had completely separated the index offence and the reason for her admission to hospital from her current diagnosis and therefore not placed any weight on these factors in managing the risk Marjorie posed to herself and others.

21. Throughout the proceedings I have considered evidence from clinicians advising that the risk Marjorie posed to herself and others was low. That said, the Dynamic Risk Assessment Matrix document stated that when Marjorie was visited by the community team she was to be visited by two members of staff because of the high risk she posed to staff.

22. On 12 August 2020 Marjorie was visited at home by the community team and expressed that she'd 'love a tablet to take this feeling away'. She also talked about dark moods. It is clear that this was not seen as a comment of concern or something to be explored further. On the basis of all of the evidence available to me and on the balance of probabilities I am satisfied that this was an expression which ought to have been considered a potential expression of suicidal thoughts by Marjorie.

23. On 3 September 2020 Marjorie had moved back into her home address. She climbed out of her bedroom window on the first floor of her property and fell from the window.

24. I am satisfied on the balance of probabilities that Marjorie was complaining of low mood. That she had returned to her home address which was the scene of the index offence and that she felt guilty about what she had put her family through; she was suffering from thoughts which might lead her to wish to end her own life. Her mood had not improved throughout her treatment and as a result of that I am content, on the balance of probabilities, that Marjorie intended to end her life and took the necessary steps to make this happen by [redacted] [redacted]. I therefore will return a conclusion of suicide in this case.

Following this I made a number of queries known to the Ministry of Justice and Sheffield Health and Social Care Trust as follows:-

In relation to the Ministry of Justice the main area of concern relates to the use of s37 Mental Health Act 1983 only and the lack of application of s41 Mental Health Act 1983 in a case of this severity. It appears that the initial diagnosis of dementia along with the Defendant's age may have been significant factors in that decision however it is plain that the eventual diagnosis of this individual did not account for the index offence. Unfortunately, because Marjorie was only detained under s37 Mental Health Act 1983 this did not allow for any monitoring of her by criminal justice agencies such as the Probation Service following her discharge from hospital. Although Marjorie was the only one who came to physical harm following her release from hospital; it may only be good luck that this is the case. For this reason I am keen to understand:-

	1. How is a decision made as to whether an individual committing an offence such as murder is detained under s37 and s41 of the Mental Health Act 1983 or just one of those sections? 2. Is there a way in which probation service can become involved at a later date where someone is detained under s37 of the Mental Health Act 1983 and it becomes apparent that the mental health diagnosis does not account for the index offence. In relation to Sheffield Health and Social Care Trust however I am inviting evidence prior to consideration of issuing a preventing future deaths report relating to the following matters:- 1. The experience of the older adults team in the use of s37/41 in respect of assessing future dangerousness and how that may impact upon discharge planning. Including any policies or procedures for how a patient admitted forensically will be supported. 2. The contents of risk assessments during Covid-19 pandemic. This relates specifically to the decision to cease face to face contact with patients and balancing that against the risk to the patient of not seeing them face to face. This should include the type of questions that are to be asked of the patient and also any information provided to the family or carers. 3. How the older adults team assess risk in a forensic case where the index offence is as serious as in this case but a swift decision was made to discharge the patient. 4. Consideration of the original offence resulting in admission where this is not accounted for by the eventual diagnosis. Risk assessments used in forensic cases by the older adults team. 5. How is communication managed with families where they are expected to take on a significant role in caring for the individual. Particularly around things to look out for or raise with the team and an explanation of how and who to raise these concerns with. 6. During non face to face contact how are the plans communicated with family and how can the Trust assure itself that appropriate information is being recorded, gathered and shared that can subsequently inform risk planning. I am grateful to the Ministry of Justice and Sheffield Health and Social Care Trust for providing me with additional evidence in relation to the concerns highlighted however there remain areas which I believe require me to discharge my duty to issue a Regulation 28 report.
5	**<u>CORONER'S CONCERNS</u>** 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 clinical evidence which the Ministry of Justice obtained in Mrs Grayson's criminal proceedings was very clear of two things (a) Mrs Grayson should not return home alone as she was likely to have deteriorated whilst in prison and

	care and she had expressed suicidal or self-harm related thoughts and (b) she should not be returned to the care of her family because, as unlikely as it may sound, she posed a continued risk to her family. 2. The Ministry of Justice evidence further asserted that there was no requirement for a s41 Order because there was no risk to the public. 3. Unfortunately, the two things expressed in the Ministry of Justice evidence, namely that Mrs Grayson should not return home alone to care for herself and that she should not be returned to the care of her family is exactly the approach that was taken with Mrs Grayson with the result being Mrs Grayson's death. 4. I am unclear why members of Mrs Grayson's family, who do not reside with her ordinarily and at the time of her offending, are not regarded as members of the public for the purposes of a s41 Order. The risk of harm to them was clear in the mind of the author and had they been regarded as members of the public this may have led to a s41 Order being made which, although potentially making no difference in this case may do in others. 5. Sheffield Health and Social Care Trust determined to do with Mrs Grayson upon discharge did not pay sufficient heed to the clinical evidence obtained by the Ministry of Justice and which was reflected in the practice at St Andrew's. 6. Sheffield Health and Social Care Trust do not seem to have joined up the actions that were recommended from the Criminal Justice proceedings and the work undertaken at St Andrew's resulting in a discharge which did not adequately reflect the risks to and from Mrs Grayson. 7. Sheffield Health and Social Care Trust did not have risk assessments which supported adequate communication with Mrs Grayson herself and instead placed an overburden on her family to advocate for her
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have 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, namely by 11th July 2022. 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: Family of Mrs Grayson, Sheffield Health and Social Care Trust and the Ministry of Justice. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.

9	**16th May 2022** Abigail Combes **Assistant Coroner**