**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

*NOTE: This form is to be used **after** an inquest.*

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. The Chief Executive of NHS England**<br>**2. The Chief Coroner**<br>**3. The President of the Royal College of Psychiatrists**<br>**4. The President of the Royal College of Nursing**<br>**5. All Interested Persons**<br>**6. The Chief Executive of NHS Scotland**<br>**7. The Chief Executive of NHS Northern Ireland** |
| A | **CORONER**<br><br>I am Professor Paul Marks, Senior Coroner, for the Coroner Area of East Riding of Yorkshire & City of Kingston Upon Hull |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 12th July 2019 I commenced an investigation into the death of Mollie Rose Stansfield, age 22 years. The investigation concluded at the end of the inquest on 9th December 2022. The conclusion of the inquest was:<br><br>**NARRATIVE - Mollie Rose Stansfield was born on 6th January 1997 in Hull and died on 10th July 2019 on Princes Quay, [redacted] [redacted], Hull after falling [redacted]. She suffered multiple injuries as a result of this fall which resulted in her rapid death. She had an underlying diagnosis of Emotionally Unstable Personality Disorder, as well as a history of drug and alcohol abuse. She was admitted to the Avondale Unit on 27th June 2019 as an informal patient, after being transferred there following presentation to Hull Royal Infirmary with a self-inflicted neck wound which was appropriately treated. Whilst there she absconded and purchased a number of [redacted] tablets, which she took, but did not tell the nursing staff who discovered it later that day. She was transferred back to Hull Royal Infirmary and treated for this overdose. Upon her return to the Avondale unit she became physically unwell and was sent back to Hull Royal Infirmary for investigation of what was thought to be a cardiorespiratory problem. This was refuted and it is likely that her physical symptoms were due to the systemic toxic effects of cocaine. She absconded from the ward on a number of other occasions and sourced [redacted] whilst absent, which she took. She suffered a fit as a result of taking [redacted] but recovered. A Section 5.2 Mental Health Act order was put in place, but was probably not valid at material times. She was discharged to step down accommodation following being declared medically fit and following assessment by a psychiatrist. She was evicted from the step down accommodation on 10th July following an altercation the previous evening, and** |

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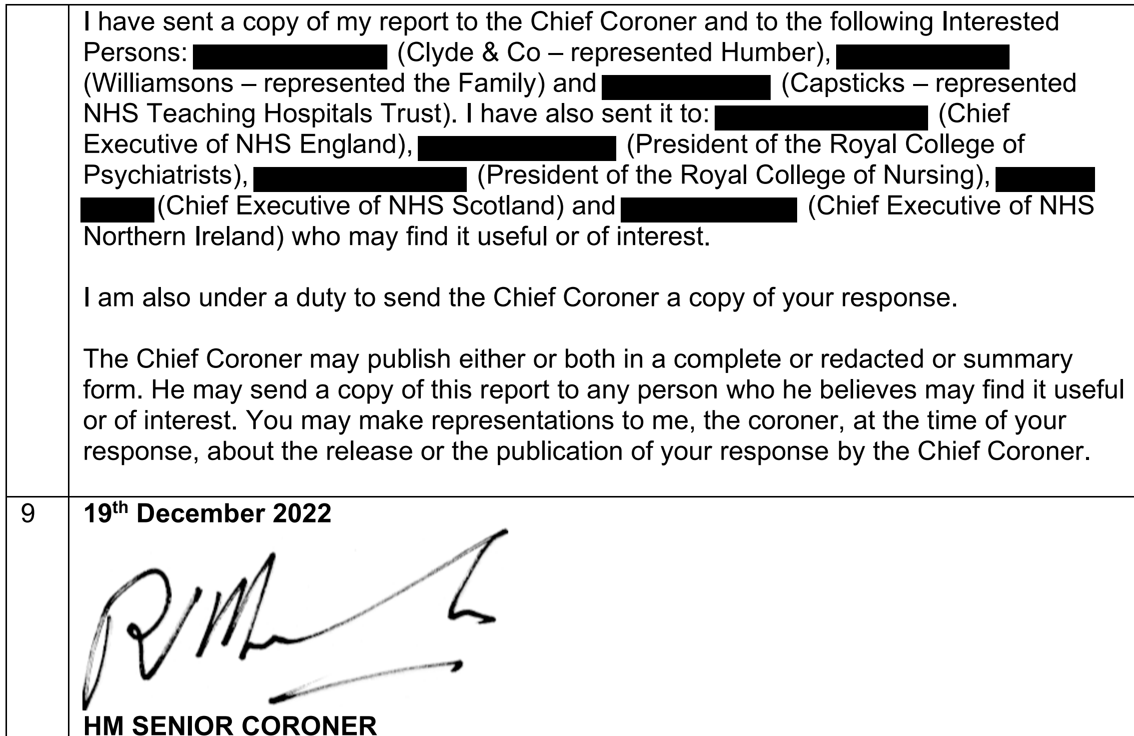
|  | **went to a high rise block of flats with the intention of jumping off. Her friend however intervened, called the police who attended the flats and removed her to a place of safety, Miranda House, under Section 136 of the Mental Health Act 1983. Following a mental health assessment at 13:00 on 10th July she was found neither to be psychotic nor intoxicated with [redacted]. She subsequently took [redacted] following her discharge and went to Princes Quay and fell to her death [redacted] [redacted] The effects of [redacted] may have clouded her judgment but equally the text message exchanges prior to her assessment at the Section 136 suite and after her release suggested that she intended to take her own life.** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>See section 3 |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>There was a failure at Hull Royal Infirmary to understand the process of implementing Section 5(2) of the Mental Health act 1983 [MHA] (Doctors Holding Power) as well as general uncertainty about its significance and effect. Mollie absconded from the ward whilst apparently under this section. The paperwork for the implementation of this section of the MHA 1983 was in fact not properly completed and hence invalid. Whilst the Hull & East Yorkshire NHS Trust has taken steps to educate doctors about this power, these were only local measures and I believe that all doctors working in England and Wales should be aware of section 5(2) and nurses of their equivalent power pursuant to section 5(4) of the MHA 1983 and that appropriate awareness and training should be given. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you as Chief executive of NHS England have the power to take such action.<br><br>Training and highlighting of this important power should be regularly delivered to all doctors and nurses about their respective holding powers. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 13th February 2023. I, the coroner, may extend the period.<br><br>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** |



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| | I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: ████ (Clyde & Co – represented Humber), ████ (Williamsons – represented the Family) and ████ (Capsticks – represented NHS Teaching Hospitals Trust). I have also sent it to: ████ (Chief Executive of NHS England), ████ (President of the Royal College of Psychiatrists), ████ (President of the Royal College of Nursing), ████ (Chief Executive of NHS Scotland) and ████ (Chief Executive of NHS Northern Ireland) who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **19th December 2022**<br><br>**HM SENIOR CORONER** |