West London Coroner Service
25 Bagleys Lane, Fulham, London, SW6 2QA
[redacted]

Date: 22 July 2022

ACTUALLY SENT 13 FEBRUARY 2023 DUE TO AN ADMINISTRATION ERROR

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

The Chief Executive, South West London and St George's Mental Health NHSTrust

Chief Coroner

CORONER

I am **Lydia Brown** the Acting Senior Coroner for **West London**

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 31 December 2020 I commenced an investigation into the death of Christopher Thomas Ace RYAN. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Mr Christopher Thomas Ace Ryan was detained under section 3 of the mental health act in laurel ward of Queen Mary's Hospital, Roehampton.
In the days leading up to Mr Ryan's death hospital notes documented he was well, compliant in taking prescribed medication and following hospital regulations on escorted leave, returning on two prior occasions on the 21st and 22nd December 2020.
No apparent concerns in needing to change his risk assessment for future escorted leave.
On 23rd December 2020 Mr Ryan absconded from escorted leave and was reported missing to the police at 13.51 by the hospital staff. He was assessed as medium risk by the police.

Conclusion - Drugs related death

Cause of death -

1a Aspiration of stomach contents

1b Central nervous system depression

1c Combined drug intoxication

CIRCUMSTANCES OF THE DEATH

Deceased was a S3. Mental health patient absconder and missing person from St Marys Hospital

Deceased has absconded from the ward and met with a friend (previous patient on the same ward) at New Malden railway station. Friend has agreed to let the deceased stay at his flat in Kingston. Deceased has bought heroin and smoked it, deceased underwent laboured breathing and lost consciousness. Friend of the deceased called LAS who arrived and carried out CPR to no avail.

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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. -

Chris was known to abscond from secure mental health detention during periods of "escorted leave". He had left the care of the Trust on 6 occasions during his final 3 month detention and was known to purchase and take illicit drugs on these occasions. His Consultant had discussed this high risk behaviour with him on many occasions.

(1) The Consultant Psychiatrist had signed the agreed escorted leave form on the basis that Chris would be accompanied 1:1 with a nurse. The purpose of the leave was therapeutic, to enable Chris to access the community in a supported manner. Evidence was before the court that the leave was only to the adjacent car park, to facilitate a smoking break, and 1 member of staff accompanied up to 6 patients. The Trust's own Root Cause Analysis report confirms that the practise was at this time for 1 staff member to accompany those patients who wished to smoke to the adjacent carpark.

(2) The car park is entirely unsecure and open to the road. Evidence given in court was that the hospital site is non-smoking, but the evidence was unclear whether the car park was considered to be part of the hospital site or separate.

(3) My concern is that there has been a tolerated blurring of the boundaries between the intentions of escorted leave for individuals under a MHA section, and the ward staff's ability to facilitate this in a meaningful and therapeutic way to benefit the patients, and that the clinical staff were not aware of this. Chris had indicated his desire to access the cash point and buy Christmas presents for his family, but there was no suggestion these requests had

been considered by the Trust and either approved or refused. Chris therefore made the decision to leave the ward, with catastrophic consequences. Has the Trust given any consideration to the provision of a "safe" smoking area that patients can access without the need to be accompanied or to use their restricted escorted leave for this purpose alone?

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 April 2023. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

Family
Probation service

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.
22 July 2022 [dispatched 13 February 2023 due to an administration error]

9 Signature 

Lydia Brown Acting Senior Coroner for West London