Regulation 28: Prevention of Future Deaths report

Heather FINDLAY (died 12.06.23)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive Officer** **East London NHS Foundation Trust (ELFT)** **Trust Headquarters** **9 Alie Street** **London E1 8DE** **2. [redacted]** **Metropolitan Police Service (MPS)** **6th Floor, New Scotland Yard** **Victoria Embankment** **London SW1A 2JL** **3. [redacted]** **Chief Executive Officer** **NHS England** **Quarry House** **Quarry Hill** **Collingham** **Leeds LS2 7UE** **4. The Rt Hon Suella Bravermen MP** **Secretary of State for the Home Department** **House of Commons** **London SW1A 0AA**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.

3	**INVESTIGATION and INQUEST** On 16 June 2020, one of my assistant coroners, Jonathan Stevens, commenced an investigation into the death of Heather Findlay, aged 28 years. The investigation concluded at the end of the inquest earlier today. At inquest, the jury came to a conclusion of death by suicide, making a narrative determination that I now attach, and giving a medical cause of death of: 1a hypoxic ischaemic encephalopathy 1b sodium nitrate toxicity
4	**CIRCUMSTANCES OF THE DEATH** At the time of her death, Heather Findlay was in the care of the East London Foundation Trust (ELFT), detained under section 2 of the Mental Health Act at Mile End Hospital. At approximately 3pm on 11 June 2020, she was on s17 escorted leave, standing with a healthcare assistant (HCA) at the front gates of the hospital having a cigarette, when she turned to the HCA, said "I'm sorry I have to do this to you" and ran away. ELFT contacted the Metropolitan Police Service (MPS) at 3.17pm, but by 3.58pm, Ms Findlay had been found by a member of the public in a nearby park.
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 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. 1. When Ms Findlay ran off, the HCA escorting her was so panicked that she did not even think of following. Ms Findlay had run across a road and so chasing her at speed did present safety considerations. However, the ELFT policy, training, culture and expectation was such, that there the HCA did not at any point consider attempting to walk after her to keep her in sight. Clinical staff must be adequately prepared for such an eventuality. That means more than simply a change in policy wording.

2. By the time the HCA rang the duty senior nurse for advice Ms Findlay was out of sight, and so the HCA was instructed to return to the ward.

   I heard evidence that an email is to be sent out shortly to explain that a new ELFT absent without leave policy will be in place by the end of June 2023. The new policy will confirm that, if it is safe to do so an escort may follow a patient who has absconded, keeping them in line of sight whilst ringing the duty senior nurse for instructions.

   However, there is no ELFT policy for what those instructions should be or even what they could include. No member of ELFT gave evidence of any organisational thought having gone into how then to progress such a situation, other than the ward calling the police to report a missing person. No member of ELFT giving evidence was able to set out what the staff member following should do.

   This appears to be a significant omission.

3. Moreover, one of the MPS policy leads in this area gave evidence that in such a situation the police would not necessarily attend, even if called direct by a hospital staff member in the street following a patient about whom they are worried.

   I spent some time examining the police regarding this point, and I was left with the impression that a clinician calling the police in what the clinician perceived to be an emergency situation might not be assisted by the police.

   That concerned me.

4. I heard that Right Care, Right Person is an operational model developed by Humberside Police that changes the way the emergency services respond to calls involving concerns about mental health. I understand that it is in the process of being rolled out across the UK as part of ongoing work between police forces, health providers and government.

   I heard that the MPS has already created a similar model under the resource and demand team. The protocol is called Affinity. It attempts to target preventable demand from the mental health trusts.

   I was told that ELFT and the MPS work in partnership, so I asked the MPS what is meant to happen if an escort is following a patient who has run away and about whom the escort is worried.

I was told that this is primarily a health problem. It was pointed out that doctors, nurses and other hospital staff have the same powers as the police under section 18 of the Mental Health Act. Hospital employees have the legal authority to take a sectioned patient into custody and return them to hospital.

However, I heard nothing of an ELFT protocol that would advise staff on the ward to come out to assist an escort who already following a patient. I heard nothing of a trust contingency plan that would allow a ward to function without the doctors and nurses needed to undertake such a task. I heard nothing of any training given to doctors and nurses in how to restrain a patient in the middle of the street and to transport them back to the ward.

From the evidence I heard, the police / health trust partnership working allows each agency to regard such a situation as the other's responsibility, whilst nobody is on the ground attempting to retrieve a seriously ill patient who is meant to be inside a locked ward for their own safety.

Whether this is a matter of policy or practice, the result is the same. If partner agency working is to be effective in caring for this extremely vulnerable cohort of patients, there needs to be crystal clear understanding by all those involved, from the highest policy maker to the most junior member of a team at the sharp end, of how to tackle these difficult situations and exactly who is meant to be doing what.

5. Evidence was given that the police classify a person at high risk as: the risk is immediate and there are substantial grounds for believing immediate risk of self harm.

   I was told by the MPS that, at the time of reporting to the MPS, trusts should volunteer their own grading of the patient's risk. The police said that they will not necessarily following the trust grading, but they regard it as a significant factor and it should form part of the MPS thinking. ELFT witnesses told me that if the police did not ask for the trust's grading then the trust would not offer it.

   I was told that, until April 2022 the grab pack prepared by ELFT for the MPS in such a situation was printed out and handed to police if & when the police attended the ward. It is now filled out on a portal as part of the reporting procedure. However, it is not clear to me how far the grab pack aligns with local policies, whether all useful information (including the trust's grading of risk) is recorded as a matter of routine, and how far the police and the trust are using the same terminology with the same definitions.

   It seems that this would benefit from consideration.

6. ELFT staff all told me that, after Ms Findlay had run off, they still graded her as medium rather than high risk. She had had long term suicidal thoughts, had made previous attempts on her life and, prior to being admitted to hospital on 20 May 2020 had purchased sodium nitrate and had planned to take this to kill herself. However, she had appeared to improve in hospital, and had been granted 15 minutes' escorted leave twice a day since 1 June without incident.

   At one point in her evidence it appeared to me that the matron, taking the point that by running away Ms Findlay had acted in a manner that was wholly unexpected by the trust, was of the view that Ms Findlay should then have been re-categorised as high risk. However, following re-examination by counsel for ELFT the matron appeared to retract this and to return to her former position that, even after she had run away Ms Findlay was only of medium risk to herself.

   It is of course a matter of clinical opinion what risk grading a patient should be given, and no person can see into the future.

   However,

   - the jury found a failure by ELFT to recognise that, by 11 June 2020, Ms Findlay was at imminent risk of suicide by sodium nitrate; and
   - any investigation following a death like Heather Findlay's presents an opportunity for sober and searching reflection.

   So I am concerned that an element of positional bias may have influenced the thinking of ELFT staff.

   I am concerned about this particularly because, when giving evidence at inquest, the ELFT serious incident investigation author was adamant that it was only appropriate for the HCA who called the police on 11 June 2020 after Ms Findlay had run away, to tell the police of a risk of self harm not of a risk of suicide. Her rationale for this was that the last time Ms Findlay had articulated a plan to kill herself, was when she was found in hospital with a ligature round her neck on 28 May 2020.

   This position seems lacking the necessary reflection.

	I draw your attention to earlier prevention of future deaths reports (PFDs) as follows: • Sent to ELFT on 8 June 2023 by Assistant Coroner Buckett following the inquest touching the death of Hilary (Billy) Guedalla, including concern regarding the failure of ELFT to inform the police of the serious suicide risk that the deceased posed to themselves; and the confusion among staff about who should be contacted and in what manner, once a patient was found to be missing. • Sent to ELFT on 25 January 2023 by me following the inquest touching the death of Andrew Largin, including concern about omissions from a serious incident investigation. • Sent to ELFT on 20 October 2021 by me following the inquest touching the death of Freeda Glausiusz, including concern about a lack of learning culture at ELFT.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and 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 7 August 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following. • [redacted], Heather Findlay's parents • Detective Superintendent [redacted] • Detective Superintendent [redacted] • Care Quality Commission for England • HHJ Thomas Teague QC, the Chief Coroner of England & Wales

	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	**DATE** 12.06.23	**SIGNED BY SENIOR CORONER** *ME Hassell*