REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Rt Hon Victoria Atkins, Department of Health And Social Care, 39 Victoria Street, London, SW1H 0EU** 2. **Rt Hon James Cleverley Secretary of State for Ministry of Justice, House of Commans, London, SW1A 0AA**
	CORONER I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 22nd June 2022, I commenced an investigation into the death of Hayley Jayne Cowan. Hayley died on the 4th June 2022. The investigation concluded on the 23rd May 2024. The medical cause of death was confirmed as 1a) Adverse event arising out of mixed drug use A jury concluded Hayley died as a result of misadventure.
4	**CIRCUMSTANCES OF DEATH** Hayley had been detained under Section 3 of the Mental Health Act 1983 since July 2021. She had a long history of involvement with mental health services and had previously been detained. She had a diagnosis of Paranoid Schizophrenia and ADHD. Hayley was a risk to herself and others. As well as her serious mental health illness, Hayley had a long history of illicit drug use. In July 2021 having set fire to her flat she was detained at the Edenfield unit within Prestwich hospital run by Greater Manchester Mental Health and Social Care Trust ("GMMH"). Hayley responded well to the re-introduction of her anti-psychotic medication and as part of her therapeutic work she was granted Section 17 MHA'83 leave. There were times when her leave was escorted and following progress it was on occasions unescorted. Her leave also progressed from being on the hospital grounds to the local Tesco store opposite and at times into the local village. There had been at least two occasions when Hayley had absconded and run off from the staff with her. She had taken drugs and then returned to the hospital. At all times she was considered to be at risk of absconding which was driven by her urge to use drugs. On the 3rd June 2022 Hayley was granted accompanied leave with a support worker to the local tesco store. Both Hayley and the support worker needed to use the bathroom and during this time Hayley absconded. She was found deceased the following day, having used drugs at a friends house where she had gone to. There was no guidance to staff as to what to do should they need to use the bathroom. There was guidance given as to what to do should a patient need to use the bathroom, therefore being out of sight. By June 2022 the court heard that Borrowdale ward had introduced a practice of "accompanied leave" by a band 2 support worker rather than the normal "escorted leave" with a band 3 worker who

	would have received enhanced training. This was due to a shortage of band 3 workers and a desire to facilitate patient leave.
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:- The court heard evidence as to the lack of consistency and clarity for Mental Health trusts in understanding and defining how Section 17 leave should be conducted. This issue was highlighted in the paper published in December 2022 [redacted], "NHS mental health services policies on leave for detained patients in England and Wales: A national audit." Journal Psychiatric Mental Health Nursing 2023; 30: 719-730. - Local policies appear to be shaped as a result of capacity - There is a lack of consistency as to how "accompanied leave" and "escorted leave" are defined. - Guidance as to whether a patient should remain in "eye-line" or at a "reasonable distance" is inconsistent and does not assist trusts in considering how trusts should The Mental Health Act Codes of Practice, Guidance from the MOJ to Forensic providers and Trust policy are inconsistent. This is particularly the case in considering whether a patient needs to be within "eyeline" or a "reasonable distance" when on leave. There is also no guidance as to how trusts instruct staff on practical matters such as what to do if the staff member needs the bathroom whilst out with a patient.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **24th July 2024** 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 namely:- - Greater Manchester Mental Health Trust 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 from. 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	Date: 29.05.24 Signed: