Regulation 28: Prevention of Future Deaths Report

Ms Katy Ann SAMUELS (died 24th April 2019)

THIS REPORT IS BEING SENT TO:

1. [redacted], Chief Executive at Coventry and Warwickshire Partnership NHS Trust
2. [redacted], The Mental Health Act 1983 (amended 2007), the Mental Capacity Act (2005) Lead for the Coventry and Warwickshire Partnership NHS Trust

1. CORONER

I am: Delroy Henry, Assistant Coroner, Coventry. The Coroner's Office, The Register Office,

Coventry City Council, Cheylesmore Manor House, Manor House Drive, Coventry, CV1 2CORONER'S

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 25th April 2019 I commenced an investigation into the death of Ms Ann Katy Samuels (aged 30 years). The investigation concluded at the end the inquest on 4th December 2020 at Coventry Coroners Court. The conclusion of the death of Mr Samuels was that death was "misadventure" with a narrative appended, a copy of which I attach to this report. A jury identified a serious failure to communicate important information and ineffective policies.

4. CIRCUMSTANCES OF THE DEATH

Katy Ann SAMUELS had that she had a longstanding history of mixed anxiety and depression, post-traumatic stress disorder, drug and alcohol abuse and a history of self-harm and attempted suicide. Ms Samuels came to reside at The Caludon Centre, Westwood Ward, Clifford Bridge Road, Coventry, CV2 2TE on 31st March 2019. She was a detained person pursuant to section 2 of the Mental Health Act at the Caludon Centre having been admitted following detention by the police using their powers to remove people to a place of safety (she had threatened to take her own life and when the police attended they removed a belt from around her neck).

Section 17 of the Mental Health Act 1983 allows detained patients to be granted leave of absence from the hospital in which they are detained. Leave is an agreed absence, for a defined purpose and duration, and is an important part of the patients' treatment plan. On 17th April 2019 Ms Samuels returned to the ward from s 17 'unescorted' leave in a state of intoxication. On 20th April 2019, the deceased went on s 17 'escorted' leave from the ward. When Ms Samuels returned, she was again intoxicated (alcohol and illicit drugs). There were multiple incidents involving the deceased (an

altercation with another patient; Ms Samuels asked staff if they knew she had previously litigated and explained that medication had helped her; physically aggression when she was denied access to wine that had been confiscated from her on 17th April 2019).

It culminated in Katy being taken to her room by staff. She was at significant risk to herself and other people. A doctor and nurse attended upon Ms Samuels in her room and then left to speak to the on-call consultant for advice and direction as to whether the deceased could be given sedation medication despite her intoxication and the appropriate level of observations.

The deceased was left in the room alone with staff outside the room attend to other matters. Shortly afterwards a member of staff went to check on Ms Samuels as part of the hourly observations.

Ms Samuels was discovered with a ligature (dressing gown cord) around her neck attached to the bathroom door within her room. Despite attempted resuscitation and hospital treatment she did not recover, and died on 25th April 2019

5. CORONER'S CONCERNS

During the inquest, the evidence and information 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:

i. The Coventry and Warwickshire Partnership NHS Trust has a section 17 Leave Policy approved and ratified on the 7th August 2019 with a next review date of the 7th August 2022. The policy is targeted at inpatient and community staff.

Excerpts from the aforementioned policy are:

> "Leave is defined as any excursion, which takes the patient outside the hospital grounds for ANY period of time, whether escorted by staff, accompanied by relatives/carers, or unescorted… Leave should be planned in advance, agreed at the multidisciplinary team meeting and consideration must be given to the legal status of the patient…. Leave should only be granted after careful planning and risk assessment that involves the patient, carers, and the appropriate community team… The patient should be able to demonstrate to professional carers that he/she is likely to cope outside the hospital... Any conditions, restrictions or limitations applicable during the leave period, along with the destination address for overnight leave, must be clearly documented on the s17 leave form. While it may often be appropriate to authorise leave subject to the condition that a patient is accompanied by a friend or relative (e.g. on a pre-arranged day out from the hospital), responsible clinicians should specify that the patient is to be in the legal custody of a friend or relative only if it is appropriate for that person to be legally responsible for the patient, and if that person understands and accepts the consequent responsibility"

ii. It is paramount that a policy must provide clear unambiguous guidance/ direction to inpatient and community staff particularly in relation escorted leave given the legal status of the patient. A lack of clear direction/ guidance can have serious consequences.

iii. The circumstances of this inquest touching upon the death of Katy Samuels accentuated this point. The evidence was that Ms Samuels (a detained patient) can and did leave the hospital grounds without an escort seen to attend the hospital. An escort's identity is not verified, even if seen, for escorted leave e.g. photo identification. A consequence was no member of staff was aware of precisely what time Ms Samuels left the hospital and if it was in fact with anyone at all. No escort was seen and there is no requirement regarding this. It was on this occasion (20th April 2019) that Ms Samuels returned from leave either alone or with an escort not seen and she was intoxicated from alcohol (toxicological evidence confirmed she had also consumed cocaine). Within hours of her return to the ward she was to be discovered with a ligature around neck.

iv. An aspect of the evidence was staff handovers are vital and therefore time to enable the same very important. The time set aside for a handover was considered insufficient by some staff. By way of analogy there was no handover to the escort for escorted leave. The evidence was that such a process of 'handover' would enable better patient safety, detained patients undoubtedly very vulnerable and at risk of significant harm to themselves.

6. ACTION SHOULD BE TAKEN

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

7. YOUR RESPONSE

You are under a duty to respond to this report within 56 days of receiving this report, namely by 8th February 2021. 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:

1. HHJ Mark Lucraft QC the Chief Coroner of England & Wales Chief Coroner's Office, 11th Floor Thomas More, Royal Courts of Justice, Strand, London, WC2A 2LL. chiefcoronersoffice@judiciary.gsi.gov.uk
2.

2. Katy Samuels' family.

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.

Date: 11th December 2020