



Record of Inquest

Following an inquest opened on the 18 August 2023 and an inquest hearing at Medico Legal Centre on the 9 December 2024 heard before Tanyka Rawden in the Coroner's area for South Yorkshire West.

The following is the record of the inquest (including the statutory determination and, where required, findings) –

1. Name of Deceased (if known)

Roger Gary LEADBEATER

2. Medical cause of death:

1a **Multiple stab wounds**

1b

1c

1d

II

3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances, the deceased came by his or her death: (see note (ii)):

Roger Gary Leadbeater died on 9 August 2023 in Shortbrook Park in Sheffield as a result of multiple stab wounds inflicted by a patient who was detained in hospital under the Mental Health Act and who had absconded from escorted leave.

The patient had been known to Mental Health Services since 2008 and had experienced psychosis and command hallucinations telling her to hurt others.

She had previously killed animals and assaulted people and she presented a risk to animals and people.

During her last admission to hospital between October 2022 and August 2023, the patient was violent to staff. She absconded nine times, attempted to abscond fifteen times, and failed to return from leave three times.

Despite handovers between police forces and between the police and the Trust not being clearly recorded, there is evidence of the patient using drugs, carrying weapons and making threats to harm people during her periods of absence.

On 4 August 2023 the patient absconded whilst on escorted leave, assaulting a friend and threatening to kill her.

After the patient absconded a risk assessment was completed by the Trust. This was lacking in detail, inaccurate, and missing important and relevant information. This resulted in the treating team not having a complete and accurate risk formulation available to them in a single easily accessible document to assist in understanding her complex clinical presentation.

There were specific questions that were central to understanding her risk at the time of granting leave that were either unanswered or not entirely answered. As a result, significant emphasis was placed on her short-term presentation in the absence of longer-term evidence-based strategies for risk mitigation.

On 7 August 2023 the patient's care was transferred to a new inpatient Consultant Psychiatrist and Responsible Clinician. The timing and nature of the handover of care between Responsible Clinicians is unclear.

During a thirty-minute board round meeting that morning a period of escorted leave was authorised. This decision was made without clear documentation of the reasons for the decision, without consideration of a detailed risk assessment, and outside of the policies which stated that leave after a suspension should be reviewed face to face at the next Multi-Disciplinary Team Meeting.

The patient absconded whilst on escorted leave and two days later her actions brought about Roger's death.

It was not reasonable or proportionate to depart from the policies and make the decision to grant leave before the next Multi-Disciplinary Team meeting the following day when a full assessment could have taken place and the newly allocated Responsible Clinician could have met the patient.

Had an up to date and accurate risk formulation been available, and had the same been considered when leave was granted on 7 August 2023, it is likely the risk factors would have been too high and leave would not have been granted.

4. Conclusions of the coroner/jury as to the death: (see notes (i) and (ii)):

Unlawful killing

5. Further particulars required by the Births and Deaths registration Act 1953 to be registered concerning the death:

(a) Date and place of birth 26 June 1949 SHEFFIELD	
(b) Name and Surname of deceased Roger Gary LEADBEATER	
(c) Sex Male	(d) Maiden surname of woman who has married
(e) Date and place of death 9 August 2023 Shortbrook Park SHEFFIELD	
(f) Occupation and usual address Minibus driver for special needs children 33 Shortbrook Close , Westfield, SHEFFIELD, South Yorkshire, S20 8LE	



Signature of **Tanyka Rawden H.M Senior Coroner**