IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of William Philip Hafele
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: Surrey Police Surrey and Borders Partnership Trust NHS Foundation Trust
1	**CORONER** Martin Fleming Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009 paragraph 7, schedule 5 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 7/11/13 I opened the inquest into the death of William Phillip Hafele, who at the date of his death was 65 years old. The inquest was resumed with a jury on 27/10/14 and concluded on 10/11/14 The jury found the cause of death to be: 1a – Asphyxia The jury arrived at a narrative conclusion as follows: William Philip Hafele took his own life
4	**CIRCUMSTANCES OF THE DEATH** Mr Hafele who had a history of mental ill health and alcohol dependence, was admitted as an informal patient to Elgar Ward, Epsom Hospital, on

	13/9/13, after he was found on Epsom Downs by the police intoxicated and wanting to take his own life. After the first 3 weeks of his admission, he was thought to have improved sufficient to consider his discharge, however due to difficulties in finding him accommodation he remained on the ward whilst his accommodation was being arranged. During this period, Mr Hafele was thought well enough to take unescorted leave from Elgar Ward. At approximately 23.19 on 1/11/13, Mr Hafele was reported missing to the police by a staff nurse on Elgar Ward after Mr Hafele had left the ward at approximately 1700 but failed to return as expected, when it was reported that earlier that day Mr Hafele had been seen by a member of staff on the ward looking at a Premier Inn web sight on a computer in the hospital. The police control room then contacted two police officers and they attended at Elgar Ward where after inquiries Mr Haffele was initially designated as a missing person. Subsequently after the police officers liaised with there duty inspector, Mr Hafele was redesignated as absent as opposed to missing, which meant immediate enquiries to trace Mr Hafele did not take place. Subsequently, the next day 2/11/13, Mr Hafele was traced to the Premier Inn Hotel, across the road from the hospital by his daughter. Upon the arrival of the police at 12.30, Mr Hafele's hotel room door was forced and he was found to have suffocated using helium gas he had earlier purchased from a local shop before checking himself into the hotel.
5	**<u>CORONER'S CONCERNS</u>** During the inquest the following concerns arose: - • Training procedures in respect of the police and hospital staff on Elgar Ward in the case of reports of missing persons and lack of understanding of areas of responsibility and appropriate actions. • Critical information required to make an informed risk assessment as to whether was missing or absent was omitted. • The decision to re classify from missing to absent was not communicated to the hospital • As a result no enquiries or investigations were made by any agency to ascertain Mr Hafele's whereabouts • Adequate training on the Surrey Wide Response Agreement and Surrey Police Missing Person Procedure did not take place • In relation to the Police, specific training with regards to risk assessments for mental health patients was lacking • Surrey Police TPT briefing training did not correspond to the definition of Absent given in the surrey Police Missing Person

	• Ineffective communications between Police and Elgar Ward I would ask that you consider giving further consideration to the procedures and systems to ensure that there is no further repetition.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Surrey Police and Surrey and Borders Partnership Trust NHS has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** • [redacted] • [redacted] • [redacted] • [redacted] • Chief Coroner
9	**Signed: Martin Fleming** **DATED this 24th November 2014**