

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

The Inquest Touching the Death of Daniel Maher
A Regulation 28 Report – Action to Prevent Future Deaths

	<p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. Fiona Edwards Chief Executive Surrey and Borders Partnership NHS Foundation Trust2. [REDACTED] Social Care Professional Lead and AMPH Lead West Sussex County Council
1	<p>CORONER Ms Anna Crawford, HM Assistant Coroner for Surrey</p>
2	<p>CORONER'S LEGAL POWERS I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.</p>
3	<p>INQUEST The inquest into the death of Mr Maher was opened on the 1 June 2016 and was resumed and concluded on 5th April 2017. The cause of death was: 1a – Hanging The inquest concluded with a conclusion of Suicide.</p>
4	<p>CIRCUMSTANCES OF THE DEATH On 26th May 2016 Mr Maher was found hanging at his home address. The emergency services were called but efforts to resuscitate him were unsuccessful and he was pronounced deceased at the scene. On 23rd May 2016 Mr Maher's partner had found him with a knife at their home address. He was upset and asked his partner to help him to kill</p>

himself. As a result she took him to A&E at East Surrey Hospital.

Whilst they were waiting to be seen Mr Maher left the hospital and, following a police search, was found in a nearby field having cut his wrists. He told the police officer who attended that he had tried to kill himself but that the attempt had not worked. He was detained by the police pursuant to s.136 Mental Health Act 1983 (MHA) and initially taken back to East Surrey Hospital where his wounds were sutured and dressed. He was then taken to the s.136 suite at Langley Green Hospital in West Sussex which, the court was told, is the closest s.136 suite to East Surrey Hospital.

In the early hours of the morning on 24th May 2016 Mr Maher underwent an MHA assessment, which was conducted by an Approved Mental Health Professional employed by West Sussex County Council and two s.12 MHA approved doctors. They jointly assessed Mr Maher as being suitable for release and referred him into the care of the Home Treatment Team (HTT) in his home county of Surrey, which falls under the auspices of Surrey and Borders Partnership (SABP).

On 24th May 2016 Mr Maher was seen by a Registered Mental Health Nurse with the HTT and on 25 May 2016 he was seen by a psychiatrist with the HTT, and he remained under their care at the time of his death.

5 **CORONER'S CONCERNS**

During the course of the inquest the court heard evidence from mental health professionals working on behalf of both West Sussex County Council and SABP.

The court was told that it was not an uncommon occurrence for patients who are detained in Surrey under s.136 MHA to be taken to Langley Green Hospital in West Sussex for assessment and then, at some point thereafter, to be released back into the care of the community health services in Surrey. Given that this is not an uncommon occurrence I have concerns regarding the sharing of information as between the respective mental health services in West Sussex and Surrey.

The **MATTERS OF CONCERN** are:

- The court was told that mental health professionals cannot access patient information which is held on the computerised systems of mental health services outside their own county. As a result, they

	<p>are dependent on seeking that information directly from their colleagues in other counties, which the court was told was a time consuming process and also impracticable in relation to mental health assessments carried out during anti-social hours.</p> <ul style="list-style-type: none"> - The court was also told that it is common practice, after a mental health assessment has been completed at the s.136 suite at Langley Green Hospital, for a verbal referral to be made by telephone in respect of patients being referred to community mental health services outside of the county. The court was told that key paperwork, such as the clinical record of the s.136 assessment, is not routinely shared on the making of such referrals. In fact that the Approved Mental Health Professional employed by West Sussex County Council indicated that she was not allowed to fax such paperwork to other agencies for reasons of data protection. - As a result of the above I am concerned that significant information relating to the clinical history, presentation and risk of vulnerable individuals is not easily accessible by the relevant healthcare professionals, in circumstances in which an individual is assessed at the s.136 suite in West Sussex, and has either previously been under the care of, or is referred back into the care of, mental health services in Surrey. <p>Consideration should be given to whether any steps can be taken to address the above concerns.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.</p> <p>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.</p>
8	<p>COPIES</p> <p>I have sent a copy of this report to the following:</p>

1. [REDACTED]
2. [REDACTED]
3. [REDACTED]
4. [REDACTED]
5. The Chief Coroner

In addition to this report, I am 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 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.

Signed: 

ANNA CRAWFORD

DATED this 18th day of April 2017