REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Sam Allen Chief Executive Sussex Partnership NHS Foundation Trust Trust HQ, Swandean, Arundel Road, Worthing, West Sussex BN13 3EP 2. Giles York Chief Constable Sussex Police Malling House, Church Lane, Lewes, BN7 2DZ
1	**CORONER** I am Karen Harrold, Assistant Coroner for the coroner area of West Sussex.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5 http://www.legislation.gov.uk/uksi/2013/1629/made
3	**INVESTIGATION and INQUEST** On 12th May 2016, the Senior Coroner, Penelope Schofield, commenced an investigation into the death of Paul Lawrence Hanton aged 52 years old. The investigation concluded at the end of the inquest on 7th December 2017. I recorded a conclusion of Suicide. The medical cause of death was recorded as: 1a) Head injuries.
4	**CIRCUMSTANCES OF THE DEATH** In summary, Paul Hanton was an informal patient at Langley Green Mental Health Hospital in Crawley since January 2016. On Monday 18th April 2016, he was escorted around the grounds of the hospital with two other patients by a member of staff. As they were returning to the ward, Mr Hanton absconded and despite a search within minutes of him leaving he could not be found either in the hospital or the near vicinity. His disappearance was immediately reported to Sussex Police. 8 days later on 26th April 2016 at 23:57 hrs, Mr Hanton jumped in front of a train as it entered Kings Cross

Underground Station. A post mortem examination was carried out on 6th May 2016 and confirmed he died from head injuries.

It was clear Mr Hanton had a complicated medical history including both physical and mental health problems over many years. In particular, he had suffered from depression since his teenage years and it was reported he had suffered from PTSD as a result of abuse. At one time there was a diagnosis of borderline personality disorder and following his admission to Langley Green, his psychiatrist, [redacted] told me his working diagnosis was depression with psychotic symptoms.

Mr Hanton's first admission to Langley Green hospital was on 26 May 2015 following two attempts to take his own life – firstly on 14 May when he took an overdose of tramadol and venlafaxine – then on 24 May when he again took an overdose of the same drugs and by cutting his brachial artery and his wrist with a knife requiring surgery.

Various attempts were made to try home leave and rehabilitation back into the community but these did not go well resulting in a Mental Health Act assessement in August 2015. Mr Hanton was deemed to have capacity but was readmitted informally due to poor self-care and persistent false concerns about money and debt.

Treatment continued and by 23 November a discharge meeting was planned but that morning Mr Hanton told staff he was going for a walk and he did not return. He was not found until 16 December by his father in Hastings, East Sussex. The intention was to go to Langley Green the following day to collect his belongings but he again went missing from home on 17th December. He was next admitted to St Thomas' hospital in London on 31 Dec after taking a large overdose of aspirin tablets in an attempt to take his own life. He was admitted with a perforated ulcer and underwent surgery. Following treatment he was readmitted to Langley Green on 13 January 2016 again as a voluntary patient.

By 22 February 2016, Mr Hanton was not keen on having an assessment at a rehabilitative unit prior to discharge home and tried to run away but was easily stopped by staff. He again talked about taking his own life and accepted that he 'freaked' out and became fixated on killing himself. His up and down mental health continued until 16 March when he went on unaccompanied leave and failed to return. On impulse, he went to Southampton where he swam out to sea with the intention of ending his life but later swam back to shore and was found by a passer-by who called the police and was returned to hospital. He told the doctor that he heard voices telling him to kill himself. Staff assessed his risk of self-harm as high so he was placed on 15 minute observations and encouraged only to have accompanied leave.

On 14 April he reportedly started a fire in his room during the night and suffered burns as a result. The 15 minute observations were resumed and discussions began to change medication to include a mood stabiliser, Lithium, and also potentially electroconvulsive therapy. Mr Hanton was not keen on this course of treatment but again he was deemed to have capacity.

The last day Mr Hanton was seen by staff was 18th April. An activity worker knew that he enjoyed the walk around the hospital grounds so she went to his room to encourage him to attend. Two other sectioned patients also joined them and the walk itself was uneventful until they all returned to the hospital café. Enroute back to the ward, they were joined by 2 relatives and passed through reception which was very busy that day. By the time the group reached the ward it was clear that Mr Hanton had gone without warning. Within minutes, the activity worker ran back to reception and checked with staff if they had seen him. Together with a colleague, they quickly ran out of the hospital grounds and searched the nearby area which she knew well. Despite a search of the hospital and grounds, he could not be found.

During the inquest she told me that she could not recall exactly who made the call to the police to report Mr Hanton missing. She was aware a second call was made by the

occupational therapist to provide additional details. After hearing from two charge nurses, it was apparent that neither regarded themselves as being the Nurse in Charge. I also heard from the Clinical Nurse Lead Manager, [redacted] who carried out a review of what happened on 18th April and he too initially did not know who made the initial missing person call to the police. Some notes were found and confirmed it was a staff member with initials [redacted] When the audio file of the 999 call was played, it confirmed a healthcare assistant had been asked to make the call when he was not fully equipped with all the necessary information readily to hand.

I heard from [redacted] of the Sussex Police Missing Person Team. He explained that the call handler on a 999 call uses a recognised list of questions to obtain the right information but it helps immensely if hospital staff can give the best information to inform the first risk assessment by the Critical Incident Inspector including, for example, description of clothing. This then helps trying to trace the person within the first hour when there is the best chance of finding them as if on foot they are likely to get no more than 3-4 miles away. Within the first hour local CCTV should be alerted and there can be area searches of bus/railway stations; trying mobile phone contact and family/friends.

In this case the call started at 11:33 and ended at 11:47 so 14 minutes long. By 11:59 the Inspector was asking for more information but [redacted] confirmed that he could not see that the Inspector recorded the risk assessment despite the information given by the hospital and CCTV monitoring did not start till 13:37, two hours after the call. The second call from the hospital was at 12:00 and gave clothing description and absconding details from 16 March including the fact Mr Hanton had gone to Southampton and left a suicide note. NICHE and COMPACT records were checked

The CAD record suggested that the incident was bouncing between the North and South Area inspectors with little effective action being taken. A local car commented on use of the rail network previously and being found in Hastings so a request was made to alert BTP which happened at 14:34. By 14:48 a local sergeant reviewed the compact report and indicated a medium risk despite the hospital having indicated a high risk of suicide. It was not until 16:51 that the North Area Inspector requested a room search and that did not occur until 20:37. This was when a broken plate with blood was found indicative of further self harm.

It was noted hospital CCTV could not be accessed and this may have helped in some cases.

A decision was made to leave the enquiries to the missing person team in the morning but at 21:26 a request was made for checks in a Hastings hotel and home address in Surrey. A home search was also requested of Surrey police and when this was done on 19 April at 02:30 there was a negative result. A further check happened at 09:17 again with a negative result.

It was accepted that no foot patrol or drive arounds were conducted.

Hampshire police were not notified until 19 April at 09:19.

The next significant event was at 00:19 on 25 April when the Met police received a call from [redacted] saying Paul had rung his parents. [redacted] set out the actions by the Met including advising the parents to obtain the telephone number and a possible location. Officers were dispatched to check phone boxes in the Haymarket /Coventry St area and also around Tottenham Hotspur Football ground even though that was 10 miles away from where the call was believed to have been made. It was hoped that Mr Hanton was on his way home.

[redacted] from BTP confirmed that at 23:50 on Tuesday 26th April a witness was on the platform at Kings Cross underground station when he saw Mr Hanton deliberately run across the platform and jump in front of a train as it was entering the station. Police found a notebook at the scene and from reading what Mr Hanton wrote there is no doubt

	he had a clear intent to take his own life.
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:- 1) Need for clear information to be given by hospital staff when making the 999 call to report a patient has gone AWOL in order to proactively answer the known risk questions and maximise the opportunity for police to take timely action to trace the patient within the golden hour. I heard from [redacted] Service Director, that when a 999 call is made relevant information would need to be drawn from several sources including the patient's form (personal/physical details & photo), any signing in/out form (last known clothing) and latest risk assessments/plan with details of recent incidents that inform the risk assessment. Inevitably, when a patient goes missing the AWOL policy needs to be followed including internal and external searches; notification of relevant senior staff etc. At times of pressure such as these it would be advisable to have all the relevant information in one location for ease of access by the designated person who makes the call. 2) Langley Green to ensure that hospital CCTV is accessible at all times for police viewing. 3) Langley Green to consider review and amendment of current AWOL policy. This may be necessary given [redacted] indication that he does not believe staff need to wait to have a discussion with clinical staff. 4) Police to ensure the initial risk assessment is clearly endorsed in the CAD and timely actions are undertaken both locally and appropriate referrals are made to other Forces. 5) Police to consider joint policy with Adult Safeguarding Board. 6) Police to consider equal response to informal as well as sectioned patients if guided by clinical staff of high risk. I heard from senior staff at Langley Green that there is a discernibly different response from police when the missing person is an informal patient rather than under a MHA order. In the latter case, often a blue light police car is immediately dispatched to the hospital and a room/locality search takes place. This is not the case with an informal patient yet the same high risk of self-harm or suicide or risk of causing injuries to others may exist. In other words, there seems to be a general perception that informal patients are less unwell.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 the date of this report, namely by 19th March 2018. 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: 1) The family of Paul Hanton; 2) Surrey and Borders Partnership NHS Foundation Trust I have also sent it to: 1) [redacted] Service Director 2) [redacted] Clinical Lead Nurse Manager 3) [redacted] Consultant Psychiatrist 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 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 by the Chief Coroner.
9	**Date: 18th January 2018** Karen Harrold Assistant Coroner West Sussex