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

The Inquest Touching the Death of Stephen Ian William Tidey
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • Ms Fiona Edwards, Chief Executive, Surrey & Borders Partnership NHS Foundation Trust, 18 Mole Business Park, Leatherhead, Surrey KT22 7AD • Ms Joanna Killian, Chief Executive, Surrey County Council, Contact Centre, Room 269-298, County Hall, Penrhyn Road, Kingston upon Thames, Surrey KT1 2DN • Mr Nick Ephgrave, Chief Constable, Surrey Police, PO Box 101, Guildford, Surrey GU1 9PE
1	**CORONER** Ms Anna Loxton, HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into the death of **Stephen Ian William Tidey** was opened on 6th January 2017. It was resumed and concluded on 13th April 2018. I found the medical cause of death to be: 1a. External Neck Compression 1b. Hanging I determined that Mr Tidey took his own life, in part, because it was not managed despite the fact that the risk of him doing so was recognised by the Criminal Justice Liaison and Diversion Service and by Police officers who completed Adult at Risk referral forms.

4	**CIRCUMSTANCES OF THE DEATH** Stephen Tidey was found hanging deceased from a tree outside a cabin in which he had been residing at Woodsmoke, Farley Heath, Guildford. He had self-inflicted wounds to both wrists and a note was found on his body stating that he intended to end his life to spare his family further suffering.
5	**CORONER'S CONCERNS** Mr Tidey was arrested on 3rd February 2016 and, whilst in police custody, a 24/39 Adult at Risk or Multi Agency Safeguarding Hub ("MASH") form was completed by police officers giving a Red RAG status with high risk of suicide indicated if his relationship with his partner and specifically his daughter were to fail, and if he lost his job, which were contingent events. He was assessed by a member of the Criminal Liaison and Diversion Service (CLDS) on the same day and was initially assessed by them as being at risk of self-harm. The member of the CLDS subsequently telephoned the Home Treatment Team to discuss referring him to the service. Mr Tidey was then re-assessed by the same member of the CLDS who stated he appeared calmer and was no immediate risk to himself. No notes were recorded on the Police or Mental Health Service computer system to record how this assessment of reduced risk of self-harm had been reached. During the following months, no contact was made by mental health services with Mr Tidey, and he did not seek their assistance. On 26th October 2016 he attended Guildford Police Station to be charged with the offences and was assessed by Police and a member of the CLDS as being at low risk of harm to self. On Friday 16th December 2016, Police were made aware that Mr Tidey had lost his job as a consequence of being charged with the offences and therefore that one of the contingent events highlighted in the MASH referral of 3.2.2016 as placing Mr Tidey at higher risk of self-harm had materialised. They therefore completed a further MASH referral form and this was emailed to the MASH hub at 15.40 and forwarded on to Waverley CMHRS at 16.41. On Monday 19th December 2016 at 11.30am, Waverley CMHRS forwarded the MASH report to Guildford CMHRS, but then emailed again at 11.36am to state they noted Waverley CMHRS should actually follow up Mr Tidey. However, for reasons, which cannot be ascertained, no further action was taken. It is not possible to ascertain who the duty

	worker was who received the referral by email. [redacted], Community Services Manager for South West Community Mental Health Recovery Service, stated in evidence that had he received Mr Tidey's MASH referral on 16th December 2016, he would have taken action the same day, initially via a telephone triage assessment and then via the options available of HTT referral; EDT Mental Health Act Assessment, crisis planning with safe havens or CMHRS non-crisis support, as appropriate. Evidence was given that there were no safeguards in place to check referrals were being acted upon, and that this remains the case. Mr Tidey was found deceased on 22nd December 2016, the day before he was due to attend Court for sentencing. The **MATTERS OF CONCERN** are: - How MASH reports are processed by the MASH team upon receipt; - Whether there is an effective system in place to ensure that MASH reports are followed up by the appropriate Community Mental Health Team (where necessary); and - Whether there is an effective system in place to deal appropriately with MASH referrals received outside normal weekday office hours, and that those completing the MASH referral forms (e.g. Police officers) know where these should be send outside normal working hours when a high risk is identified Consideration should be given to whether any steps can be taken to address the above concerns.
6	**ACTION SHOULD BE TAKEN** 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.
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** I have sent a copy of this report to the following: 1. See names in paragraph 1 above 2. [redacted] 3. 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 LOXTON** **DATED this 8th day of May 2018**