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

The Inquest Touching the Death of Henry James Heselton
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • **Julie Dawes the Chief Executive Officer of Southern Health NHS Foundation Trust , Tatchbury Mount, Calmore, Southampton, SO40 2RZ**
1	**CORONER** Caroline Topping HM Assistant Coroner for the County of Surrey
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.
3	**INVESTIGATION and INQUEST** An inquest into the death of Mr Henry James Heselton was opened on 7th October 2016 and resumed on 26th January 2018. It was concluded on 4th April 2018. I concluded that Mr Heslton died on the 28th September 2016 at Down Lane Guildford. and that the medical cause of his death was: 1a Hanging Henry Heselton died at Down Lane, Guildford. He had suffered from paranoid schizophrenia for many years which had been controlled by medication. He had expressed suicidal ideation for many years. It is not possible to find what triggered the relapse of his mental health which led him to take his own life nor whether more proactive mental health support could have prevented his death. He hanged himself on the 28th September 2016. Conclusion as to death; Suicide
4	**CIRCUMSTANCES OF THE DEATH** Mr Heselton was born on the 30th January 1985. He obtained 2 degrees and worked as an audiologist at Royal Surrey Hospital in Guildford. He was a very conscientious young man. In 2008 he was diagnosed with paranoid schizophrenia. His mental health care was provided by a community mental health team from Southern Health NHS. He did not want any treatment to impact on his work. A care plan was put in place which accommodated his wishes and which relied on his Mother to be his carer. Mrs Heselton was authorised to liaise with mental health professionals on his behalf. Her contribution was regarded as an integral part of his care plan. In addition, Mr Heselton's GP surgery made arrangement for Mr Heselton to have regular blood tests because of the

	medication he was taking. This involved him attending the surgery on a monthly basis and seeing one of the nursing staff. He saw his psychiatrist for annual reviews. He did not want a care co-ordinator. On Sunday the 28th August 2016, on a bank holiday weekend, [redacted] rang the East Acute Mental Health Team crisis team run by Southern Heath Trust. Her son was in crisis. She sought advice about medication. She said that she thought Mr Heselton might kill himself that day, he could be heard highly distressed in the background. The crisis team was one member of staff short that day. The mental health nurse practitioner answering the phone did not have time to read Mr Heselton's medical records. She suggested ringing an out of hours GP. No follow up call was made to [redacted] and the call was not subject to a multi-disciplinary discussion. Details of the call were forwarded to the community mental health team. They were not at work until the following Tuesday. Mr Heselton's general practitioner, [redacted], was not notified of the call. On Wednesday 1st September 2016 Mr Heselton's psychiatrist, [redacted], called [redacted]. He was informed that Mr Heselton's mental health had deteriorated but from the information provided by [redacted] he did not regard Mr Heselton to be at significant risk. He made an appointment to see Mr Heselton on the 23rd September 2016 after he had had his blood test at the surgery. This call was not notified to [redacted] said she thought Mr Heselton would not attend the psychiatric appointment. On the 7th September 2016 Mrs Heselton called [redacted] to discuss Mr Heselton's mental health and ask about medication. From the information she was given [redacted] did not think Mr Heselton was actively suicidal. That assessment was made without [redacted] having been made aware of the 2 recent contacts with [redacted]. [redacted] was therefore not able to make a fully informed decision about Mr Heselton's treatment and was not able to undertake a fully informed risk analysis. On the 23rd September 2016 Mr Heselton attended at the surgery to have his blood tested but did not attend his psychiatric appointment. On the 27th September 2016 [redacted] was unable to contact Mr Heselton. She tried to call the police but did not use 999. She feared he had killed himself. The following day she was notified that Mr Heselton had not arrived for work. She called the police and Mr Heselton was found in a field off Down Lane Guildford. He had hanged himself. [redacted] told the police he had been talking about killing himself for 4 days. An investigation by Southern Health Trust concluded that there had been a missed opportunity to engage with Mr Heselton and to have a mental health assessment on the 28th August 2016. In addition, that it was essential that staff answering crisis calls familiarise themselves with the patient's mental health records. Professor Fox a Consultant Psychiatrist gave evidence as an expert at the inquest. In his view the 3 contacts with [redacted] should have raised alarm about Mr Heselton's mental state. More should have been done to engage and support [redacted] and communication should have been better between the crisis team and the community mental health team, and with [redacted]. He accepted that, given Mr Heselton's reluctance to engage with mental health services, the decision whether to undertake a mental health assessment of Mr Heselton was a difficult one and may have undermined his therapeutic relationships with the mental health professionals.
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 could 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. The electronic mental health records were unclear. Vital information about Mr Heselton's mental health history, including that he had attempted suicide in the past, was difficult to find. His most recent care plan did not record this. The information was not easy to extract for professionals needing to find information about a patient in a crisis. 2. There was a lack of communication between the mental health teams and the general practitioner. The fact that contact had been made by [redacted] with both the acute and community mental health team was not shared with his General Practitioner. This left her without relevant recent history to inform her clinical judgement when she was contacted by [redacted] on the 7th September 2016.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 July 2nd 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 following: 1. The Chief Coroner 2. [redacted] 3. [redacted] 4. [redacted] 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	**Signed:** **Caroline Topping** **Dated this May 18th 2018.**