	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Ms Cressida Dick Commissioner for the Police of the Metropolis New Scotland Yard 35 Victoria Embankment Westminster London SW1A 2JL
1	CORONER I am Miss Sarah Ormond-Walshe, HM Senior Coroner, South London jurisdiction
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	INQUEST: Ms Catherine Anne Horton
4	CIRCUMSTANCES OF THE DEATH A jury found the medical cause of death was: 1a) Suspension II) Paranoid Schizophrenia

	How, by what means and in what circumstances, when and where did the death occur: The evidence shows Miss Catherine Horton died in [redacted] at sometime between the 16th and 24th of July 2017, by hanging herself, as a paranoid schizophrenic patient under section 3 of the Mental Health Act 1983. It is reasonable to expect that Catherine should have been under the direct care and supervision of Gresham 1 Ward, Bethlem Royal Hospital. The evidence suggests that the circumstances which contributed to Catherine's death were as follows: - Catherine absconded from Bethlem Royal Hospital at 01:36 on the 10th July 2017. - There was a failure by ward staff on night shift duty from 9th July 2017 - 10th July 2017 to adequately observe Catherine, note her absence and report her absconsion. - The administrative EPJS was ineffective in recording the date of receipt and content of notes Catherine handed to staff. These notes were known to be Catherine's primary method of communication whilst on the ward. They failed to be correctly fed into the relevant patient notes and reports. - Catherine's risk assessment was not correctly updated and did not accurately reflect the risks that were relevant in her case. - The grab pack prepared on the 10th July 2017 to assist the police was unacceptable and contained serious omissions and inaccuracies. - The management structure of the ward failed to provide adequate leadership and to correctly delegate responsibility to individuals to co-ordinate the safe return of Catherine to the ward. - There was a deficiency in the understanding of how to execute a section 135(2) warrant once it was obtained. This led to an unacceptably long period of time between obtaining and executing the warrant. - The above failures and omissions were causative of Catherine's death. - There was no effective care plan for Catherine We cannot say one way or the other if this failure was causative of Catherine's death. Conclusion: A suicide conclusion proved on the balance of probabilities, to which neglect contributed.
5	CORONER'S CONCERNS The **MATTER OF CONCERN** is as follows. – During the course of the investigation, the evidence has revealed a matter giving rise to concern that in my opinion means that there is still a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. There were multiple failures in the days leading up to Ms Horton's death. During the evidence it was made clear that a mistake was made in relation to closing a missing person investigation relating to the deceased (before a Safe and Well check had been undertaken). This occurred at a time when staffing was low and the

	expectations of the Officer or Officers working on particular days was well above what was achievable. Particularly, on the day the investigation was incorrectly closed was one where the unit was dealing with 28 missing person enquiries. I strongly suspect that resources are stretched in every department of the MPS. However, the missing persons' unit may not be seen as readily as other departments as a life-saving department. Of course it is because of the vulnerable nature of the persons missing and I am told that Croydon has the highest figures of missing persons in Europe. At the time of Ms Horton's death, an error was made that coincided with staff being re-located elsewhere and the senior officer giving evidence said that the error was made due to pressure of work. I have sufficient concern about a wider issue which warrants the writing of this Prevent Future Death Report (CJA 2009, Schedule 5, Paragraph 7; Regulation 28 Coroners (Investigations) Regulations 2013) to be sent more centrally.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths. I am asking the MPS to ensure the missing persons unit has sufficient Officers working in it at busy times, so as to make their job achievable, and to minimise the likelihood of mistakes happening.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th March 2019 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. If you require any further information or assistance about the case please contact the Coroner's Officer, on [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons: The family of Catherine Horton South London and Maudsley NHS Trust

	[redacted] Independent Office for Police Conduct [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	**[DATE]** 15th January 2019 **[SIGNED BY CORONER]** P.P.