The Inquest Touching the Death of Miles Ethan Hurley
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: 1. National Chief Police Council 2. Chief Executive NHS England 3. Chief Constable Sussex Police 4. Midlands Partnership University NHS Foundation Trust Liaison Diversion Service 5. MITIE
1	CORONER Dr Karen Henderson, HM Assistant Coroner for West Sussex
2	CORONER'S LEGAL POWERS I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	*On 7th May 2024 I resumed an investigation into the death of Miles Ethan Hurley sitting with a Jury. On 20th May 2024, the investigation was concluded:* *The medical cause of death given was:* *1a. Multiple Injuries* *1b. Acute Psychotic Episode Secondary to Chronic Cannabis Dependency* *The jury determined:*

Miles was diagnosed in 2016 with testicular cancer and required surgery and chemotherapy. From this point Miles began to suffer social anxiety, depression, and body dysmorphia. Although he began using cannabis from the age of 13, Miles began using cannabis to self-medicate and developed a chronic cannabis dependency.

During this period Miles had limited engagement with his GP or other NHS services, preferring to self-research and self-medicate. This resulted in very limited medical records being held in NHS systems. Miles did seek to reduce his cannabis use during 2019, endeavoured to seek mental health support and was exploring garden therapy and garden work. He received some private mental health care however records are no transferred to NHS systems. During the period 5th - 8th July 2022 Miles became increasingly delusional, agitated and scared with mood swings; fuelled by time alone, time awake and time interacting on the internet. Miles developed a belief in conspiracy theories and formed a view that his family were in a cult.

On the 8th July 2022 Miles went missing and caused damage by throwing a breeze block at a Member of the Public's car. This was reported to the Police by a Member of the Public and a CAD record created. Miles' family also reported Miles as missing and provided information stating this was out of character and that his mental health was impaired. Miles returned to his home of his own volition around 10.30pm on the evening of the 8th July 2022. The Police were unable to attend the Miles' home to complete the Return Home interview.

On the 9th July 2022 Miles left home around 8.30am in the family car and interacted with an off-duty police officer at his home address. His wife telephoned the Police via 999 and they described how Miles presented and identified his behaviour as indicating mental health issues. An additional CAD record was added to reflect a Member of the Public's report that Miles was presenting with mental health issues indicating a risk to himself in a public place. Miles went on to drive dangerously causing high risk to himself and members of the public, including failure to stop, pursuit cancellation and damage to police vehicles. It was noted during the pursuit that Miles 'fist bumped' through the window.

Miles was arrested around 11.10am on the 9th July 2022 for criminal damage, dangerous driving and driving under the influence. At the time of his arrest Miles was presenting behaviour that could be perceived as intoxication and/or mental ill-health. In the following interactions and prior to being remanded into custody Miles conveyed signs of mental ill-health. Limited information related to these interactions and previous supporting mental health concerns were passed from arresting officers, to transporting officers to custody staff.

Miles was remanded into custody around midday 9th July 2022 and subsequently breathalysed to determine his level of intoxication being three times the legal drink driving limit.
During custody a mental health assessment was requested from SLDS to ensure mental ill-health was identified. An initial assessment was not undertaken on the basis Miles was intoxicated; however a second assessment was undertaken on a 'provisional' basis despite a level of intoxication still being present. This assessment did not recommend a mental health assessment via Section 136 but did recommend a further SLDS assessment if conditions were met or Miles requested. Miles declined further assessment.

The notes from the Mental Health Helpline call were not taken into consideration in this assessment and no further assessment was requested by the Police from a change in behaviour.

Miles' family called Police around 12.41pm on Saturday 9th July 2022 to establish hi whereabouts and likely custody process, followed by calls to the Sussex Mental Healt Line between 4.30pm and 8.09pm to provide information related to his mental health and concerns regarding his safeguarding in the event of being released.

The family attended the Crawley Custody suite from lunchtime that Saturday to express their concerns, and during this time were called by Police to put their request for an Appropriate Adult, a mental health assessment and a solicitor with mental health background. Miles subsequently selected the duty solicitor to attend his interview.

Adult Social Services phoned Police around 8.30pm to relay concerns from Miles' family and recommended an Appropriate Adult for lack of mental capacity, a mental health assessment via Section 136. Miles was interviewed shortly thereafter Saturday 9th July 2022 with the duty solicitor in attendance.

No further assessment of Miles mental health was undertaken and no overt mental health illness was displayed during his time in custody. During the period from his arrest to release, Miles was assessed and managed well in terms of his physical health needs however in respect of his mental health needs a number shortcomings were identified:

	The SLDS assessment was undertaken whilst Miles was intoxicated CAD mental health background information was not communicated through parties handover notes did not reflect information available SLDS service not available after 8pm Saturday *Health information from family/helpline was not passed into records* *Decisions were taken without the holistic information available as a result of different systems and abilities to assimilate information.* *Miles was released from custody to the care of his family around 10.30pm on the 9th July 2022 and returned home to be cared for by his family who took turns at keeping him safe until around 5.00am when he agreed to be taken to A&E.* *At around 5.00am Miles took his father's car, despite his parents endeavours to stop him and intentionally drove towards an HGV lorry on the A23 where a collision caused his death at 5.58am on 10th July 2022 whilst being unaware of the consequences of his actions due to a psychotic episode.*
	CIRCUMSTANCES OF THE DEATH The findings of the jury comprehensively describe the circumstances relating to Mr Hurley's death.
5	CORONER'S CONCERNS **1. Lack of effective Communication between police officers** The absence of a formal written handover between police officers regarding how an individual is presenting to be able to more accurately assess and appropriately direct assessment and care, particularly for first time offenders such as Miles who was not known to the police. Prior to and at the time of his arrest he was recognised by members of the public and the arresting police officers as showing significant signs of disturbance in his mental health with

incongruent speech, inappropriate behavioural affect, and delusional beliefs such as thinking he was playing 'Grand Theft Auto' whilst driving recklessly, on a background of intoxication. The extent and the severity of his mental health difficulties was not adequately conveyed through standard 'word of mouth' communication between police officers, complicated by Mr Hurley appearing to be more contained and less obviously mentally unwell in custody.

2. Lack of relevant Documentation by the Police

Throughout Mr Hurley's time in custody on the 9th July 2022, his parents spoke to multiple police officers and allied staff on the phone and on attending the custody suite to inform them of their concerns over their son's sudden deterioration in his mental health on a background of longstanding extreme social anxiety. Whilst this was generally known by the officers within the custody suite, there was no formal documentation, either individually or collectively of these concerns to inform and assist police officers in their decision making.

3. Lack of effective documentation and communication between the Liaison Diversion Service (LDS) and the police within the custody suite.

a. The use of word of mouth rather than formal written documentation of a mental health assessment compromised the Police's comprehension of the complexity and nuances of Mile's mental health difficulties to assist in determining the most appropriate care.

b. The lack of a documented recommended mental health 'plan' by the LDS to be followed whilst an individual remains in custody.

c. A lack of nationally agreed guidelines as to when it would be appropriate to undertake a formal mental health assessment when an individual is known to be intoxicated when first detained. I heard evidence that it is not possible to rely on the findings of a formal mental health assessment if undertaken when an individual is intoxicated. Yet, The LDS mental health practitioner was tasked to do so in those circumstances resulting in a 'qualified' assessment the significance of which was not recognised prior to Miles's release from custody.

c. A lack of guidelines to support a LDS practitioner as to when it is appropriate to undertake a formal mental health assessment if an individual is intoxicated rather than feeling obliged to do so because of their availability. I heard evidence that the LDS mental health practitioner worked from 08:00-20:00 and would not have been available after those hours hence the request for an earlier mental health assessment.

d. A lack of a 24 hour LDS service within custody despite mental health issues being prevalent throughout the day and night for individuals in custody.

d. A lack of effective guidelines to assist the police on decision making as to whether an individual needs a further mental health assessment and/or an Appropriate Adult. The on call social worker (having spoken to Miles's father), contacted the police to raise concerns about Miles's mental health

and the need to have a mental health assessment and an Appropriate Adult present. This was deemed not necessary by the interviewing officer. There appears to be a conflict in that the police accept they are not qualified to formally assess mental health issues but on the other hand they relied on their assessment that Miles did not need a further mental health assessment or for an appropriate adult to be present.

e. Difficulty in being able to obtain collateral information to assist in a mental health assessment from other Mental Health Services. Evidence was heard that members of Miles's family contacted the Mental Health helpline with their concerns whilst Miles was in custody but were not afforded the opportunity to share these concerns with the LDS practitioner which would not have been a breach of confidentiality.

4. Memorandum of Understanding between Midlands Partnership University NHS Foundation Trust, Sussex Police and Mitie

The MOU does not adequately address the practical issues facing an LDS and the police services to ensure appropriate management of mental health assessment and ongoing care whilst an individual is in Custody. There is an absence of local or national 'Standard Operating Procedures' or guidelines as to when to obtain a mental health assessment if an individual is intoxicated, a lack of formal documentation procedures, or steps to be taken to encourage further sharing of available information between the LDS service and the police (the LDS practitioner was not fully informed of Miles's presentation at arrest, was not informed of the concerns raised by the family regarding Miles's acute deterioration in his mental health and

	had no access to police records to be better informed). Nor are there any appropriate templates available with regard to liaison between LDS and the police to to ensure consistency and accuracy of available evidence.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph 1 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. [redacted] – Family Solicitors 2. West Sussex Social Services 3. Sussex Partnership NHS Foundation Trust 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:  Dr Karen Henderson DATED this 9th Day of August 2024