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

The Inquest Touching the Death of Hannah BAMPFYLDE
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • [redacted], Chief Executive, Sussex Partnership NHS Foundation Trust, Swandean, Arundel Road, Worthing, West Sussex BN13 3EP [redacted]
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 **Hannah Bampfylde** was opened on 30th April 2020. It was resumed on 30th March and concluded on 28th April 2021. I found the medical cause of death to be: 1a. Hanging I determined that Hannah took her own life. Hannah had taken an overdose of medication in October 2019, as a result of which she was referred by the Psychiatric Liaison Nurse who assessed her at East Surrey Hospital to Time to Talk service, but this referral was rejected by Time to Talk as Hannah's suicide attempt rendered her condition too severe for the service. Her GP then made a routine referral to Horsham Assessment & Treatment Service ("HATS"), part of Sussex Partnership NHS Foundation Trust ("the Trust"), for Mental Health

	Service input. Two assessment appointments were made for Hannah; on 26th November 2019 and 4th December 2019 (subsequently changed to 6th December 2019). These appointments were recorded as DNAs, although I heard evidence Hannah had moved address so may not have received appointment letters and, when notified of the change in the second appointment by text message, was only told the time of this on the day itself when she would already have been at work. No further appointment was made and therefore no action was effectively taken to progress Hannah's referral until March 2020, when the Assessor noted Hannah's name remained on her caseload and discussed her with the Referrals Coordinator at HATS. An Opt-in /Contact letter was sent on 4th March 2020 informing Hannah that, as she was recorded as having failed to attend two appointments, she would be discharged back to the care of her GP unless she made contact by 20th March 2020. Hannah was herself made aware of this when she attended the Urgent Treatment Centre at Crawley Hospital on 5th March 2020 reporting volatile mood and was seen by a Specialist Nurse Practitioner in Psychiatry, who notified her of the letter and advised her to contact HATS. Hannah was subsequently discharged back to the care of her GP on 1st April 2020 without having been assessed by HATS.
4	**CIRCUMSTANCES OF THE DEATH** Hannah Bampfylde was found hanging deceased in the garage of her Mother's home address, where she had been staying, in Horley, Surrey. A note was found dated 26th March 2020 in Hannah's bedroom in which she stated she could not carry on living.
5	**CORONER'S CONCERNS** Hannah Bampfylde had a long history of mental health problems and was diagnosed with Borderline Personality Disorder. Following a settled period, her mental health deteriorated leading to the attempted overdose in October 2019. Following an unsuccessful referral to Time to Talk services, Hannah was referred to HATS, the entry point into specialist mental health services. Assessment appointments were made for 26th November 2019, which

	Hannah did not attend, and 4th December 2019, which was altered at short notice by HATS to 6th December 2019, when Hannah was at work. No further appointments were made by HATS and Hannah did not contact the service herself to reschedule. Hannah's GP was not made aware that she had missed appointments and that she was not therefore effectively under the care of the service until HATS wrote to the GP on 1st April 2020 advising them that Hannah had been discharged for non-engagement. Whilst there was not sufficient evidence before the Court to conclude that the lack of an assessment by HATS and therefore Mental Health Services input into Hannah's care caused or contributed to her death, the evidence highlighted a lack of clarity and potential for persons newly referred to the service to not engage without their GP being aware of this. The two GPs who had contact with Hannah both stated they were unaware of any protocols being in place, either at the time of Hannah's death or in the interim, to ensure all non-engagement with services should be communicated with the patient's GP, although the Trust's own Serious Incident Report into Hannah's death identified that such a protocol should be in place. HATS use the Trust's "Active Engagement Incorporating Did Not Attend (DNA) Policy & Procedure" ("the Policy") in governing the standards of how to promote engagement with service users, to include those awaiting assessment and those already under the care of the service. The Policy provides general guidance to professionals in deciding on the action to be taken when a person does not attend an appointment with them, but does not give a clear pathway to avoid newly referred patients slipping through the system. From the evidence given to the Court, it was not clear who was responsible for re-booking appointments in the event of a DNA, or at what stage non-attendances should be escalated for review with the Referrals Co-ordinator. The Policy describes a "Multi-Disciplinary Review Meeting" taking place prior to a non-attending person being discharged back to primary care, but this does not apply to new referrals to the HATS where a Multi-Disciplinary team would not be in place and discussion would instead take place between the Assessor and Referrals Co-ordinator. There was no detail of this discussion in Hannah's notes although evidence was given that it had taken place.

	The **MATTERS OF CONCERN** are: - Appointments are not automatically re-booked when a person has failed to attend an appointment. - It is not clear who should re-book appointments when a person has failed to attend (Administration or Assessors). - GPs are not routinely notified if a person has not attended an appointment with the HATS, meaning the GP would be unaware the person was not receiving input from the HATS until they had failed to attend a number of appointments and were discharged back to primary care, potentially many months after being referred. 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] Partner, Bindmans LLP, 236 Gray's Inn Road, London WC1X 8HB [redacted] 3. [redacted] Associate Director of Legal, Sussex Partnership NHS Foundation Trust [redacted] 4. 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 5th day of May 2021**