REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: [redacted] **Chief Executive** **Horsham District Council** **Chart Way** **Horsham** **West Sussex** **RH12 1RL**
1	**CORONER** I am **PENELOPE SCHOFIELD**, senior coroner, for the coroner area of **WEST SUSSEX**
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 INQU EST** On 23rd April 2019 I commenced an investigation into the death of in James Herbertson which concluded at the end of the inquest on 25th November 2020. At the end of the Inquest I concluded "James Kenneth Herbertson, who at the time of his death was under the care of the community mental health team, took his own life whilst the balance of his mind was disturbed. In the days leading up to his death there was a failure to recognise and act upon the clear signs of his mental health relapse and provide him with the additional support he needed." Following the Inquest, I indicated that I was minded to make a Regulation 28 report but would like to hear submissions from the Interested Persons. Submissions have since been received from the family and those representing your Trust. I have fully considered these submissions prior to preparing this report and I apologise for the delay in finalising this Regulation 28 report.

4	**CIRCUMSTANCES OF THE DEATH** On the 10th April 2019 at 17:32 hours, James Kenneth Herbertson was struck by a train on the railway near to Crawley train station. His death was confirmed at scene. James had a history of mental health difficulties. He was first involved with the mental health services in 1998 following a mental health episode which resulted in him being

	sectioned. However, he absconded and took off for Amsterdam. We heard that James returned home in April 1999 when he received treatment from the mental health services. This resulted in a diagnosis and prognosis in 2000 of symptoms of schizophrenia with possible effects of substance misuse and depression. James left the UK again and moved to France. He then remained in France over the next 17 years although he did return home from time to time for short periods. The next key milestone was in January 2018 when the family became aware that his mental health had deteriorated again. James eventually returned home to the UK on 22nd March 2018. In June 2018 James was detained under the Mental Health Act and admitted to Langley Green Hospital where he remained before being discharged to the care of the Community Mental Health Team on 17th August 2018. His family felt he was ill prepared for discharge. He declined the offer of a bed at a hostel and slept rough for several nights before eventually being found emergency accommodation at the Grange Hotel. Both the initial accommodation offered and the accommodation at Grange Hotel were unsuitable for someone with the mental health and alcohol misuse issues that James had. James was allocated a Lead Practitioner to support him upon discharge. However, she had not been involved at the point of discharge. In the months leading up to James' death his family had become increasingly concerned about him. James fluctuated as to what involvement he would let his family have. At the beginning of April 2019 James started to discuss moving back to France however his Lead Practitioner told him that she did not think it was a good idea. She did not think his mental health was stable enough. His Lead Practitioner then had a period of leave. On her return on the 8th April she spoke to James. On the phone James was incoherent. He would start a conversation but would not finish it and he made mention that he wanted to go back to Hospital. He was clearly showing signs of a relapse. On 9th April James' presentation was discussed at a multi-disciplinary meeting. Details of Lead Practitioner's assessment of him from the previous day was shared with the team and a decision was made to put him on "Red Zone". This meant he was to be monitored more closely. However, it did not appear that the team had identified that James' was becoming acutely unwell. Therefore, there was no referral made to the crisis team. It was left for his Lead Practitioner to monitor him. This was a missed opportunity to render care particularly as his Lead Practitioner would not have been available to contact him on the following day (10th April) as she had been allocated to be the duty worker. On 9th April James sent his lead practitioner a text message asking for return contact. This was sent after 5.00pm and was not seen by her that evening or the following day James took his own life the following day on 10th April at 17.32 hours.
5	**CORONER'S CONCERNS** During the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. –

	Discharge from Langley Green Hospital – August 2018 - Sussex Partnership Trust and Horsham District Council (in respect of the Housing issue) a) The discharge arrangements from Langley Green Hospital did not include the Lead Practitioner who was going to be the primary contact responsible for providing the support to James following discharge. Although she had met him once no therapeutic relationship had been established and at the point of discharge, she was not aware that discharge had taken place. b) Although James was vulnerable his parents were also not aware of his discharge at the point of discharge and therefore were unable to offer support. c) The accommodation offered to James both on leaving hospital (and subsequently) was not a safe and therapeutic environment for a person who had recognised mental health difficulties with a history of alcohol and substance misuse. Whilst accommodation is a matter for the Local Authority the Trust staff work with partner agencies in the planning for a S117 discharge. A separate regulation 28 report has been sent to Sussex Partnership Trust detail this and a number of other issues.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe your organisation have 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 10th May 2021. 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 Chief Coroner and to the following Interested Persons: - [redacted]**, parents of the deceased.** **Sussex Partnership Trust.** 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 March 2021**  **Penelope Schofield, Senior Coroner**