In the inquest touching the death of Hannah Mary AITKEN
Ms Anna Loxton H.M. Assistant Coroner for Surrey

Findings and Conclusion

Introduction

1.The Inquest touching the death of

a. th September 2023 and recent refusal to engage with mental health professionals, whilst under a Community Treatment Order. Should this have raised concern/consideration of recall to Hospital?

b. How did Hannah come to have [redacted] in her possession? [redacted]

c. The regulation and supply of [redacted]

in self-harming by cutting, and then also in restricting food intake, often vacillating between the two as coping mechanisms.

7. Hannah was referred to the Child and Adolescent Mental Health Services, but refused to engage. but she refused mental health input and became increasingly withdrawn, refusing to attend school or leave her bedroom. Her parents struggled to keep her safe. In March 2017, Hannah was first assessed under the Mental Health Act and admitted under section 2 to Springfield Hospital, where anorexia nervosa was identified, and whilst there, she attempted to take her own life by ligature.

8. Mr Aitken has provided a detailed background of the struggles Hannah faced over the following five years, much of which were spent as an inpatient within seven different hospitals for mental health treatment, often far away from Surrey, and therefore her Family, depending on bed availability. These admissions did not form part of the scope of this inquest, but I accept evidence that Hannah suffered greatly as a result of her long periods in inpatient settings. I note that concerns have been ide

eligible for s117 Mental Health Act 1983 aftercare. Hannah was assessed as requiring

increased to two support staff during the day, and one support staff at night. Initially, this increase in staffing levels was to support Hannah with her increased physical needs as she was in a wheelchair and recovering from her injuries, but Surrey County Council agreed that she needed ongoing 2:1 support during the day because of her high level of risk and of absconding, and the burden this placed on a single member of staff. This level of support continued following further reviews on 2nd September and 1st November 2022.

17. In April 2023, Hannah was recalled to hospital due to breaching her Community Treatment Order by refusing to engage with health professionals, and then

21. Ms Lucas clarified in evidence that she did not view this as a crisis, and indeed her Rather she stated that this was a heads-up to all that there were some concerns, but that otherwise Hannah was still going about her daily routines of taking Milo for his walks and broadly complying with staff.

22. The following day, 14th September, Bridget Nyamatanga started her duty as a support worker at 8am, with support worker Beauty Hluyo starting her working day at 10am. Hannah had taken her medication the previous day in the evening, and Ms Hluyo gave evidence that sometimes Hannah would refuse to take medication from certain members of staff but would take it from others, and they would keep offering this to her during the course of the day until she accepted it.

23. Both Ms Hluyo and Ms Nyamatanga described that Hannah took time to build a relationship with people, and that she wanted her own space within her home. On occasion she would allow favoured carers to sit with her, but generally she preferred them to remain in the office within the flat, with very few allowed in her bedroom and only in the living room if invited by her.

24. Both recalled that Hannah th September. Ms Hluyo recalled Hannah greeted her appropriately when she arrived, and she took Milo for a dog walk with Ms Nyamatanga, chatting to her about her concern Milo had not yet toileted and then chatting with another dog walker whilst on the walk.

26. During this time, FedEx records that a parcel was delivered to Hannah and received by her at 2.09pm. Ms Nyamatanga, Ms Hluyo and Ms Hall were all clear in their evidence that they did not see a delivery take place, and could not explain how this occurred without them being aware of it. Whilst Hannah had previously ordered medication online, and there had been concern about her receiving parcels and prompts for staff to ask her to open these in their presence, I accept that they could not force her to do so. This was an extra precaution put in place when there was an awareness of a parcel having arrived, which was not the case on this occasion.

27. There is no evidence before the Court as to how Hannah came to receive the parcel, albeit the possibility was raised it could have been passed through her bedroom window to her. Hannah had been noted to be looking out of her window that morning, and had been able to spot Ms Ball approaching the Flat. Hannah was able to go out of her flat to toilet Milo or to smoke her vape, but she was not unaccompanied outside the flat on 14th September. I cannot determine how Hannah came to receive the parcel, and to conceal it from staff, but she was not meant to be under one to one observations at the time.

28. Review of emails following her death found that she had attempted to order [redacted] on or around 26th August 2023. However, they asked her to complete a declaration of order [redacted] from this company was subsequently cancelled.

29. On 12th September 2023, Hannah chased up an order of [redacted] she stated she placed [redacted] She received an email on 30th August from the company asking her to confirm the purpose of buying [redacted] and she replied the same day that she intended to use it for [redacted] It was this order [redacted] which was delivered to Hannah on 14th September 2023.

30. Hannah went into the living room and played with Milo, sitting0.054 245.93u5>4 804F004 6Qq92

31. SECAmb were then called, with the time of the call recorded at 14.47, and informed Hannah was vomiting, shaking and had taken an unknown overdose. The first attendees were Oliver Reed, Ambulance Technician, and Lauren Thorpe, Trainee Associated Ambulance Practitioner, who arrived at 15.00. At that time, Hannah was unconscious and pale but still breathing, and she was immediately given high flow oxygen. As her respiratory rate dropped, she was administered an i-gel and ventilation commenced. A second crew then arrived, consisting of a Newly Qualified Paramedic and Emergency Care Support Worker

appointments, generally he described that she did not make eye contact; gave one-word answers at best or would simply refuse to engage at all. At her last appointment with him at her home on 6th September 2023, she refused to speak to him except to tell him to go away. However, as this was in character with her usual behaviour,

41. However, when Ms Ball met with Hannah on 17th May, she appears to have quickly built up a rapport, taking on board the best approach was to talk to Hannah about Milo, and not directly regarding her mental health. Following this, Ms Ball was able to undertake reviews in person on 1st June, 15th June, 6th July, 17th

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46. Unfortunately, plan was not effectively updated following her hospital discharge. In failing to do so I find there was a missed opportunity to provide Hannah with clear information as to the care she would receive, in her

51. Whilst there are certainly aspects of her care which raise potential issues under Prevention of Future deaths, and upon which I will be hearing further evidence I accept Dr Mynors-Wall health difficulties, which had a huge impact on her and lead to feelings of hopelessness, and that sadly this may have remained the case even had best practice been followed.

Care provided to Hannah by Brookhaven Care

52. Turning then to the care provided by Brookhaven, the providers of supported accommodation contracted through Surrey County Council and part funded by the Care Commissioning Group, I find that this was appropriate, and in fact I find that

Dr Mynors-Wallis gave evidence that the detailed Support Plan put in place by Brookhaven was comprehensive, giving support staff clear background and guidance as to expectations and how best to manage Hannah, and this was . In particular,

support her during those times.

53. Staff were on hand to provide support to Hannah, and did so, respecting her need for privacy but assisting her when she required. It was not Tm0 g0 GkW her when she required

reflects the genuine consideration they had for her welfare. I did not find any deficit in care provided by Brookhaven staff which could be said to have contributed to I note only positive support.

55. th September 2023, noting

flagging up early concerns. I agree with Dr Mynors-
not a red flag of imminent danger, and his view that;
that there would have been a very serious self-
Warning signs were flagged up, but these did not indicate an impending crisis.

56. I cannot therefore find that the events of 14th September were foreseeable or preventable by Brookhaven that day or her ability to order online and take delivery at home of

Care provided by Social Services, Surrey County Council

57. As already detailed, I find that there was a good support package made available to Hannah via Brookhaven, through Surrey County Council and the CCQ. I did note the lack of record keeping
which became apparent during evidence by Ms Bocean .
She stated this

that had Hannah have been given methylene blue at any time prior to suffering cardiac arrest, she would have survived.

60. However, in his oral evidence to the Court, he clarified that he was referring to a scientific possibility; a hypothetical scenario; and not to the circumstances faced by those ambulance staff treating Hannah on 14th September. This conclusion was reached based on the hypothesis
treating her; that they had access to methylene blue and they were able to administer it prior to cardiac arrest occurring.

65. I therefore do not find on the evidence that there was any prospect of Hannah survival following ingestion of [redacted] on 14th September given the [redacted] consumption was not known; attending ambulance staff had no knowledge or training of this substance; and the antidote was not available.

66. I then turn to consider the evidence I heard in this inquest regarding Prevention of Future Death, and whether methylene blue can and should be available to first

evidence, I heard evidence from the following:-

- Dr Magnus Nelson, SECAmb Assistant Chief Medical Officer;
- Dr Philip Cowburn, Medical Adviser, National Ambulance Resilience Unit; and
- Dr Alison Walker, Chair of the Joint Royal Colleges Ambulance Liaison Committee and Executive Medical Director for West Midlands Ambulance Service.

67. Dr Alison Walker detailed the trial of the use of methylene blue that has taken place within the Hazardous Area Response Team (HART) at West Midlands Ambulance Service (WMAS) from July 2020. This was instigated by Dr Walker, recognizing that in certain scenarios it may be possible to save lives following [redacted] consumption via administration of methylene blue, and that HART units are uniquely able and qualified to undertake this.

68. Dr Walker gave evidence that in the nine cases of [redacted] responded to by WMAS carrying methylene blue, this was administered to four patients. Three of these survived following Emergency Department admission, with the fourth already in cardiac arrest, who did not respond to treatment. Of the remaining five cases where methylene blue was not administered, four were deceased at the point of ambulance arrival; and one did not show indications of [redacted] Dr Walker therefore stated three lives had been saved as a direct result of WMAS HART unit carrying methylene blue. Dr Cowburn detailed that WMAS call out to [redacted] cases represented one case for every half a million 999 calls, describing it therefore as a very rare, albeit increasing, incidence.

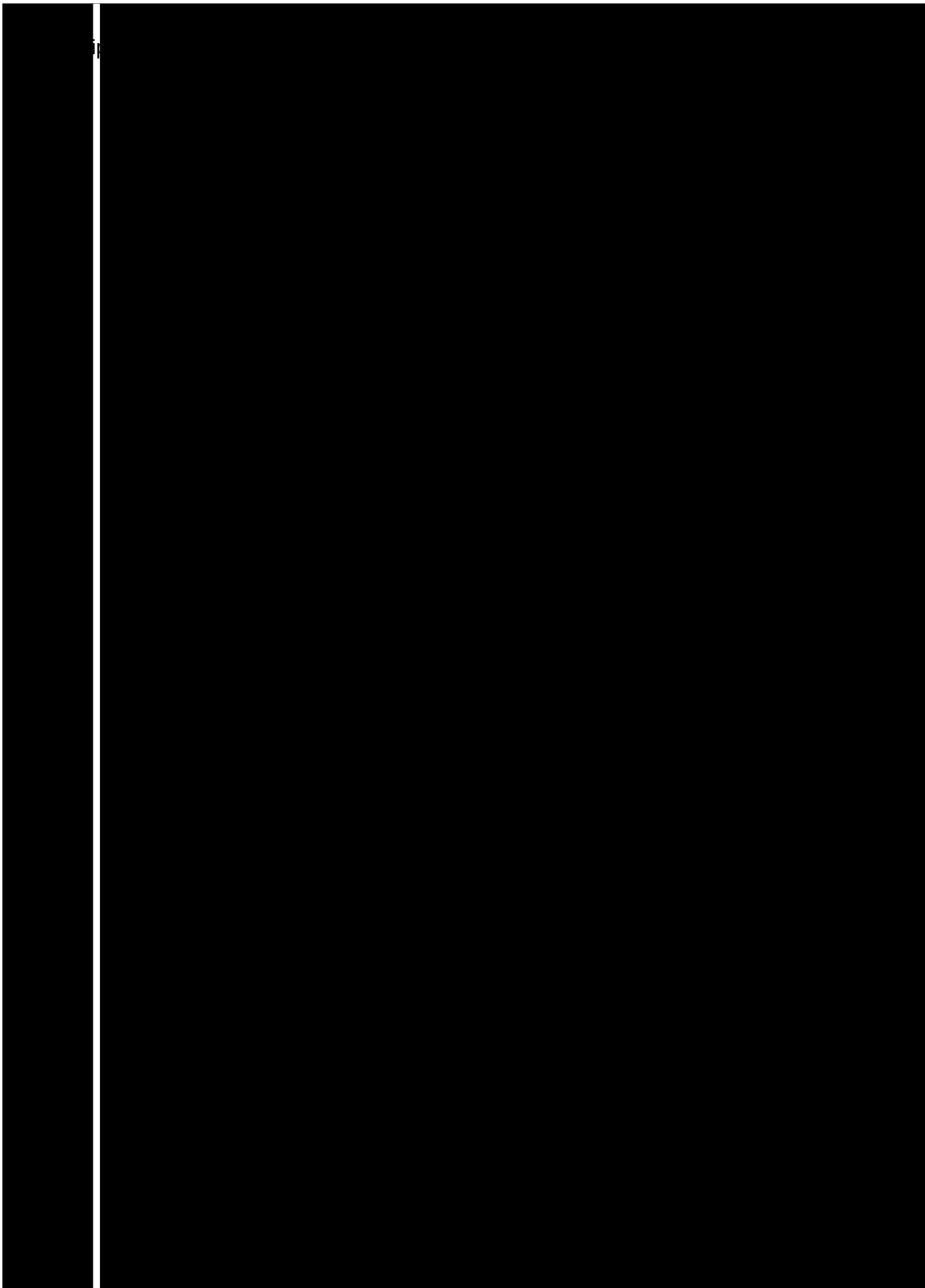
69. As a result of this trial, Dr Walker and Dr Cowburn detailed that they anticipate other ambulance trusts will commit to trialing methylene blue in their HART units, but that this would be a decision for each individual Trust. I understand that this is under active consideration at present by a number of Ambulance Trusts, as the National Ambulance Resilience Unit, and that the feedback from a recent clinical subgroup meeting has been positive for further trials.

must be made in the round, and against competing consideration of other drugs and equipment which may have a higher demand for use.

75. Having therefore heard extensive evidence regarding the carriage of methylene blue, I am satisfied that this is not only on the radar of those responsible for this decision, but is under active consideration. I appreciate that this is multi-factorial, and the complexities of these mean careful consideration and further trials are needed. I am satisfied that these are in hand and that a Prevention of Future Death report on the carriage of methylene blue by ambulances is not required on that basis.

Regulation of the supply of [redacted]

76. Finally,



further to and which do not appear to have been considered by the Home Office.

that broader preventative policies have also been proved to be effective. He cited as examples the limitations placed on amount of paracetamol that can be purchased in a single transaction; the change in gas in domestic ovens and the use of collapsible rails in inpatient mental health settings as examples of policies which have reduced deaths by suicide. Therefore, I find that further consideration is required as to whether access to these substances by the general public can be limited. Based upon the evidence of Mr Hipgrave, I believe that this falls under the remit of the Department of Health and Social Care in looking to reduce suicide risk, with potential involvement from other departments. There also appears to remain potential for the Home Office to further consider whether it can limit access, for example by regulating the use of both substances via licence under the Poisons Act.

89. It is clear further consideration of this risk and whether it can be reduced is required. It is also clear that ownership needs to be taken as to which Government department is best placed to take this take this forward. I will issue a Prevention of Future Death report to the Department of Health and Social Care and the Home Office highlighting the ongoing availability of these substances against their increased use in self-harm, and the need for further consideration of steps to monitor and address such risks. It is not for this Court to dictate how this should be undertaken, but to identify the risks for consideration.

Other Prevention of Future Death issues

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the very prompt and specific care needed to attempt to counter this. Dr Walker stated that identifying what the patient has taken on the initial phone call is crucial to providing prompt appropriate treatment, and therefore survivability.

93. NHS Pathways/NPIS were not identified as Interested Persons in this inquest, and I have received no evidence in relation to what questions are asked during phone triage in suspected overdose cases which may identify [redacted] toxicity. In the first instance I will therefore write to NHS Pathways/NPIS for further information in this respect before considering whether a PFD report is required.

Surrey County Council

94.

matter. I appreciate the concern that much of the evidence given by Ms Bocean

evidence that Hannah was very well supported by Brookwood Care, and therefore available resources were prioritised for those more urgently requiring Social Care input. Records should of course always be accurately maintained, but I view this as a training exercise rather than a PFD matter, and one which I would expect to be addressed by Social Services at Surrey County Council.

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which would have increased the possibility of identifying and remedying the failures which were responsible for the death.

102.

Home Office in this inquest that it is not the correct department to take steps to limit access to [redacted] outside the sphere of its use as a terrorist threat, against reassurances previously given. I note the response of the Home Office to the Prevention of Future Death report in relation to the death of Dr

options, including working with or alongside officials of other Government , but that no evidence to support this has been provided to the Court.

103. Whilst the evidence before this inquest has identified an ongoing need for further consideration as to whether steps can be taken to reduce access by the public to [redacted] I cannot find that such steps should have been taken, and therefore that there has been a systemic failure to do so. The use of [redacted] as a method of suicide has been shown anecdotally and in the limited figures before the Court to be increasing, and this has identified that further consideration is needed as to whether access to it should be limited, and if so, how this could be effected.

104. I find that this is an ongoing and evolving e278.69 lh4r (cce)-rn(.)]TJETQq0 792 m0 0 l612 0

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Record of Inquest

106. Turning to the Record of Inquest, the Family have asked me to review the cause of death provided and consider amending this from 1a) [redacted] Toxicity. I have considered this, but note that the toxicology report is clear that both [redacted] were detected at fatal levels. Professor Lyons gave evidence that the body converts [redacted] but not vice versa. As both were detected following toxicology, both should be recorded. I will however record the full names of [redacted] and will amend intoxication to Toxicity at 1a. I also agree

at Part 2 of the cause of death, given that the evidence I heard is that these mental health conditions contributed to her death with an increased risk of suicide. I will I believe this is a manifestation of those conditions, similar to self-harm cuts.

107. I find that the test for suicide is met on the evidence before me. Hannah ordered [redacted] with the intention of ending her life, recording her wishes in the event of her death in her notebook and including a note to her parents expressing her regret and appreciation of their support. These notes appear to have been written some weeks prior to

Box 3:
On 14th September 2023, Hannah Aitken died at her supported accommodation in Caterham, Surrey, from an overdose of a poisonous substance, [redacted] which she h.67 6o3 (e)-3 o6 669.796 l142398*nBT/TT1 12s hich