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 Hannah Mary Aitken was opened by Mr Simon Wickens on 28th September 2023. Interested Persons were identified as:

    a. Peter Aitken and Amanda Aitken, Hannah's Parents, and Brother Matthew Aitken, represented by Tayyiba Bajwa of counsel, instructed by Leigh Day, Solicitors,
    b. Surrey and Borders Partnership NHS Foundation Trust, represented by Christopher Wombell of Clyde & Co, Solicitors,
    c. Brookhaven Care, represented by Matthew McDonagh of counsel, instructed by Hempsons, Solicitors,
    d. Surrey County Council, represented by Adam Taylor of counsel,
    e. South East Coast Ambulance Service, represented by Eva Pendreigh, Head of Legal Services,
    f. Association of Ambulance Chief Executives, represented by Georgia Jaddoo, of Capsticks, Solicitors
    g. Home Office, represented by Adam Farrer of counsel
    h. Take It Global have also been recognised as interested persons, based in Malaysia, but declined to take an active role in the inquest process

2. Four Pre-Inquest review hearings have taken place, on 22nd January, 24th May, 21st August and 17th September 2024. The Inquest was heard over the course of 5 days, between 30th September and 4th October 2024.

3. The purpose of this inquest, like all other inquests, was to answer the four questions required under section 5 of the Coroners and Justice Act 2009, namely who died; when and where did the person die, and how did they come by their death. The agreed scope of the inquest included the following issues:

a. Hannah's reported refusal to take her medication on the morning of 13th 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].

d. Training of emergency care professionals to respond to suspected [redacted]; the availability of methylene blue as an antidote; and whether the failure to administer this more than minimally contributed to Hannah's death.

4. I now turn to my findings and conclusion in this inquest. I am grateful for the Submissions in this respect received on behalf of Interested Persons, which I have taken into consideration. Unless otherwise stated, my Findings and Conclusion have been reached on the balance of probabilities. I will not detail all the evidence before the Court, but will rather explain by reference to what I consider to be the pertinent parts of the evidence heard between 30th September and 4th October why I have reached my findings of fact and conclusion.

Hannah

5. In light of the evidence before me, I am satisfied that the person who died was Hannah Mary Aitken. Hannah was born in Guildford, Surrey on 14th June 2001, her parents' second child. Her marital status was single and she was not employed at the time of her death. Hannah lived at a residential address in Caterham, Surrey, and it was there that she died on the afternoon of 14th September 2023. She was identified in death by Ms Bridget Nyamatanga, Support Worker, at the address.

Background

6. Hannah's parents detailed that Hannah enjoyed a happy childhood, with normal development. Hannah actively participated enthusiastically at school and in extra-curricular activities during her primary school years. She had difficulties with her hearing, but this was resolved with grommets and did not cause ongoing problems. However, the transition to secondary school was a difficult one, and Hannah struggled to adjust to the larger, noisier environment. Sadly, this manifested itself

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. Hannah's mental health continued to decline, 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 the Family's evidence that Hannah suffered greatly as a result of her long periods in inpatient settings. I note that concerns have been identified subsequently following inspections with the care provided, and allegations of abuse.

9. Hannah was left with a fear of male staff; exposure to and learning from self-harming methods of other patients; and a level of institutionalisation which made it very difficult for her to subsequently care for herself in the community. She also lost years of education. Hannah's transition from child to adult mental health services was found to have lacked planning, which added to Hannah's anxiety and set back her recovery.

10. Hannah was diagnosed with Autistic Spectrum Disorder (ASD) in 2018, with an additional diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), borderline personality traits, and an unspecified eating disorder. Dr Laurence Mynors-Wallis, the Court appointed Expert Consultant Psychiatrist, explained that these are often overlapping diagnoses in those with ASD, and he outlined the difficulty in supporting and managing patients with these conditions. He also outlined that there has been very significant development in recent years in understanding the care requirements for those on the autism spectrum, and that hospitalisation only assists in the immediacy of keeping a patient safe when in crisis, but otherwise can offer no benefit for these patients.

11. Maria Bocean, Social Worker and Assistant Team Manager at Learning Disability and Autism Team, Surrey County Council, detailed that the need for Hannah to be supported in the community was identified in November 2020, with Hannah being

eligible for s117 Mental Health Act 1983 aftercare. Hannah was assessed as requiring support with all aspects of independent living and was therefore put forward for a supported living placement.

12. Kudzai Lucas, Manager of Brookhaven Care, detailed that they were able to provide supported accommodation for Hannah. Initially this was via a placement in a shared house in December 2020, but it was soon identified that shared accommodation was not suitable due to Hannah's sensory needs and support requirements. Following a further inpatient admission, a plan was put forward by Brookhaven to support Hannah in an individual flat, and a package of care was agreed for 1:1 support, 7 days a week, in a two-bedroom flat. This would enable her to be supported at all times by a carer, in her own environment.

13. A carefully planned transition took place, with Ms Lucas ensuring Hannah was involved in decoration choices for the flat, and later agreeing that she could have a much longed for puppy. This dog, Milo, would become a great source of comfort for Hannah, and also a means by which those involved in her care could build a rapport, as Hannah enjoyed talking about her dog. Hannah moved into her home in Caterham from October 2021 under section 17 leave, and was discharged there from December 2021.

14. Ms Lucas prepared a detailed Positive Behaviour Support plan for Hannah, with input from her parents and social worker, and this was adapted and amended when required. This set out strategies to support Hannah, and identified green, amber, red and blue strategies depending on her behaviour, to assist staff in identifying challenging behaviour and supporting Hannah through this. Hannah was supported at her accommodation by an all-female team, with (initially) 24-hour support from one member of staff at a time.

15. Hannah was re-admitted to Hospital under section 3 of the Mental Health Act between 12th January 2021 and 26th May 2022, following a serious overdose. She was eventually discharged under a Community Treatment Order, the conditions of which were to take medication as prescribed by mental health services; to keep appointments with mental health services and to engage with community support. Tandridge Community Mental Health Recovery Services (CMHRS) took over her care following discharge.

16. On 17th June 2022, Hannah attempted suicide by jumping from a motorway bridge, and sustained spinal injuries and a broken heel. Once discharged from medical care, Hannah returned to her supported accommodation and her support was

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 refusing her medication. She spent a further month in hospital, and was then discharged on similar conditions under a further Community Treatment Order on 19th May 2023, back to her supported accommodation and Brookhaven's care, with ongoing support from Tandridge CMHRS.

18. The above does not detail all the events that occurred within this time frame, but provides some background to contextualise the events which fall under the remit of this inquest.

Events leading to 14th September 2023

19. In the immediate leadup to Hannah's death, she was not engaging with the Tandridge CMHRS, and was on occasion refusing to take her medication. She had not actively engaged with her Psychiatric Consultant and Responsible Clinician, Dr Martin Schmidt, since she transferred to his care in June 2022. 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, Dr Schmidt considered this was not out of character with her usual behaviour, and did not in itself warrant a referral to the Home Treatment Team (who Hannah did not wish to engage with) or a return to Hospital.

20. On 13th September 2023, Ms Lucas wrote an email, copied to Hannah's Social Worker, Maria Bocean; Judith Farrer, Health Care Planner at Surrey Heartlands Integrated Care Board; Dr Martin Schmidt, Consultant Psychiatrist; Tracey Ball, Care Coordinator and support staff at Brookhaven advising them that Hannah had declined her citalopram and was showing initial signs of deterioration. These were described as "an increasing expression of negative thoughts and suicidal ideation, poor engagement with professionals and declining to attend appointments (both mental and physical health) and now escalating to medication decline".

21. Ms Lucas clarified in evidence that she did not view this as a crisis, and indeed her email ends “I will keep you updated if concerning risky behaviours start”. Rather she stated that this was a heads-up to all involved in Hannah’s care 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’s behaviour was not concerning on 14th 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. They both recalled that when in low mood, Hannah would avoid eye contact, but during that morning she had communicated well. They referred to the refusal to take medication as not particularly out of the ordinary, but something they were used to and would keep offering during the course of the day, and Hannah would tend to accept it from a preferred support worker.

25. Having received the email Ms Lucas sent at 19.46 on 13th September, Care Coordinator Tracey Ball from Tandridge Community Mental Health Recovery Service (CMHRS) went to review Hannah in person on 14th September. Ms Hluyo and Ms Nyamatanga recalled they were aware Ms Ball was due to visit. Hannah did not seem to be aware that the visit was to take place, and she refused to see Ms Ball when she arrived on her doorstep at around 2pm, and instructed the support staff not to let her into the flat. Ms Ball, Ms Hluyo and Ms Nyamatanga recalled Ms Ball stayed for around 20 minutes, trying to negotiate with Hannah from the doorstep, and then talking to Ms Nyamatanga outside the flat by her car, but still within eyesight of the flat.

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 Hannah's 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 use form, and when she failed to do so, Hannah's order [redacted] from this company was subsequently cancelled.

29. On 12th September 2023, Hannah chased up an order of [redacted] she stated she placed "last week" with a company based in [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. After Ms Hall had left Hannah's front door, Ms Hluyo and Ms Nyamatanga recalled Hannah went into the living room and played with Milo, sitting on the sofa watching television. She then began shouting and her support workers found her vomiting, complaining of stomach ache. She was offered paracetamol but said she had taken an overdose, although she would not say what of, and there was no packaging near her to evidence this.

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. Hannah was administered Narcan but declined into cardiac arrest at 15.35.

32. Paul Crouch, Critical Care Paramedic, then arrived on scene at 15.39. Hannah was in cardiac arrest and she remained in Pulseless Electrical Activity throughout extensive resuscitation efforts. There was no information available to SECAmb to suggest [redacted]. The packaging was subsequently found in a drawer by attending Police underneath some sheets in Hannah's bedroom following her death, but there was nothing to clarify what she had taken on an initial search by her carers and then by ambulance staff following her collapse. Mr Crouch stated he had no experience of this substance in his twenty-year career with SECAmb to have recognised this possibility.

33. Hannah's time of death was recorded at 16.26 by Mr Crouch. Following post mortem, with toxicology undertaken, her cause of death was given by Dr Adel Aboumar Muhaisen as [redacted]. Toxicology also found a higher than therapeutic level of citalopram in Hannah's blood, but I find that this medication was kept and administered to Hannah by her carers, and therefore was likely a result of post mortem redistribution rather than an excess taken prior to death.

Care provided to Hannah by Tandridge CMHRS, SABP

34. Hannah had a difficult history of engagement with mental health services, and this remained the case in the immediate leadup to her death. Her ASD meant that she needed time to build a rapport with staff and open up to them, and her past history meant she was not able to engage with male staff and had a deep distrust of Psychiatrists.

35. Dr Martin Schmidt, Psychiatric Consultant and Hannah's Responsible Clinician, recalled the difficulties he had in getting Hannah to engage with him following her transfer to his care in June 2022. Whilst on occasion she had engaged at

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, Dr Schmidt did not believe this warranted a referral to the Home Treatment Team (who Hannah did not wish to engage with) or a return to Hospital. He described her as firm but polite in her refusal to engage.

36. Hannah had not found Home Treatment Team care helpful in times of crisis. The nature of this service meant it could not provide consistency in terms of specific staff attending and appointment times, which meant Hannah refused to engage with them as she needed familiarity of staff and planned appointments. The CMHRS were therefore best placed to provide her with care, in a supported home environment.

37. Dr Schmidt utilised the framework of a Community Treatment Order to encourage Hannah to comply with attending appointments, but he also accepted that pushing Hannah further was likely to lead to further disengagement. Dr Schmidt emphasised the need for a good relationship between a patient and care coordinator, whose role it would be to provide more regular contact and interaction.

38. Hannah's Care Coordinator was therefore best placed to build a relationship with Hannah. Hannah's previous Care Coordinator changed in January 2023, and was replaced by a male member of staff. Hannah's reaction to this was entirely foreseeable, given her known fear of male members of staff, and she refused to see him. The attempted visits by this member of staff caused her great distress.

39. However, from February 2023, her allocated Care Coordinator was changed to Tracey Ball. Ms Ball joined the team as a locum that month and was immediately allocated to Hannah.

40. Ms Ball first engaged directly with Hannah on the day of her discharge from Farnham Road Hospital on 17th May 2023. Ms Ball had made attempts to meet with Hannah prior to this, on 5th and 19th April 2023, but Hannah had not engaged. There had been a plan for Ms Ball to meet with Hannah weekly on the ward, which did not take place. I find there were missed opportunities to try and build a rapport with Hannah during the admission between 20th April and 17th May, which Ms Bell explained as being due to work pressures from her caseload and prioritising those in the community requiring her input. Ms Ball did not attend the regular ward review meetings for Hannah.

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 August.

42. Whilst this did not accord with the expectation of two weekly visits, Ms Ball outlined the attempts she had made to see Hannah on other occasions. There are documented occasions on SystmOne where Ms Ball attempted to visit Hannah and was unsuccessful. Ms Ball gave evidence that she had tried to visit Hannah on other occasions, often ad hoc between other clients, but Hannah had refused to see her or had been asleep. She had not documented all these unsuccessful attempts. In the absence of recording these occasions, it is not possible to determine the extent to which Ms Ball made efforts to engage with Hannah.

43. Ms Ball stated that despite the deficit in anticipated direct contact with Hannah, she was able to keep track of her via Brookhaven staff, who she stated were "absolutely amazing". Ms Lucas agreed in her evidence that Ms Ball had engaged with her and responded promptly when required. Indeed, following receipt of Ms Lucas' email on the evening of 13th September, she emailed back the following morning and attended in the afternoon. Whilst Hannah refused to see her on that day, Ms Ball attempted to engage with her from the doorstep and took time then afterwards to discuss Hannah with her carer outside the property.

44. I appreciate the concerns raised by the Family regarding whether further efforts could have been made by Tandridge CMHRS to engage with Hannah. I find despite Hannah's complex needs, there was a lack of documented consideration of how best to engage her. For example, whilst Hannah was referred to the Neurodevelopmental and Learning Disability Service, to advise those involved in her care on how best to engage with her, there is no record of the advice from the two meetings that took place. It appears that a further Professionals Meeting was to be arranged to follow up on this, but the expectation was for Ms Ball to arrange this. She gave evidence that she was unaware of this, and therefore no further meeting occurred. This was a missed opportunity to provide all those involved in Hannah's care with recorded advice regarding how best to engage with her.

45. Dr Mynors-Wallis detailed that those with autism require the framework detailed in the acronym SPACE; namely sensory; predictability; acceptance; communication and empathy. I accept his evidence that seeing Hannah in her own home was a positive example of this in action, as was a previous occasion when Dr Schmidt had sent a letter outlining her care.

46. Unfortunately, Hannah's care 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 expressed preferred format of writing. I accept that in those with Autism, clear, predictable and dependable plans are essential, and an up-to-date care plan and multi-agency care plan would have assisted Hannah, and those caring for her, in providing support tailored to her specific needs and in managing her expectations.

47. However, I cannot find that there was an omission in Hannah's mental health care which I can conclude contributed to her death, and this was also the evidence of the Court appointed expert, Consultant Psychiatrist Dr Laurence Mynors-Wallis. I accept Dr Mynors-Wallis' assessment (following the further oral evidence before the Court) that whilst the frequency of contact between Hannah and her Care Coordinator did not meet the plan on discharge for two weekly meetings, it would be speculative to conclude that this would have had such a major input that it would have altered the outcome. I also find that when a deterioration was flagged up in Hannah's presentation on 13th September, this was promptly responded to by Ms Ball.

48. I note as positives the extensive psychological therapy offered to Hannah via South London and Maudsley Self Harm Outpatient Service, but sadly Hannah disengaged from this.

49. In considering the mental health care provided to Hannah in the period leading to her death, I am satisfied that following a history of difficult inpatient admissions, it was appropriate for Hannah to be cared for in the community in so far as this was possible. I appreciate that in times of escalating risk, when Hannah was at immediate danger of suicidal ideation, inpatient admission had to be utilised to protect her and get her through periods of crisis. However, this was not a long-term solution for her, and other than safeguarding her in the immediate term, the inpatient setting could not offer any positive input for Hannah. Rather I heard that inpatient admission was detrimental to Hannah's overall wellbeing with the sensory overload this presented.

50. I accept Dr Mynors-Wallis' evidence that parts of Hannah's mental health care were good, and that even if best practice applied to all aspects of her care, sadly given the severity of her illness, it cannot be concluded this may have changed the outcome. Her life was very constrained and difficult due to her mental health condition, and this in turn contributed to her feelings of hopelessness.

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 from SABP, I cannot therefore find that these were causative in Hannah's death. I accept Dr Mynors-Wallis' description of Hannah's longstanding severe mental 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 careful consideration was given to Hannah's needs and how best to support her. Dr Mynors-Wallis gave evidence that the detailed Support Plan put in place by Brookhaven was comprehensive, giving support staff involved in Hannah's care clear background and guidance as to expectations and how best to manage Hannah, and this was used by all those involved in Hannah's care. In particular, this set out Hannah's warning signs for deteriorating mood, and how best to 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 the role of the support staff to provide 1:1 observations, as might be expected in a mental health hospital setting, but rather to unobtrusively provide support from the dedicated office at the property. Hannah was thereby able to maintain independence and a level of privacy not possible in an inpatient setting, whilst also having staff on hand to support her. Daily and nightly records were made to ensure smooth written handovers between staff and to keep Ms Lucas updated on Hannah's progress, in additional to oral handovers, and weekly notes were also made. These were detailed and informative.

54. I note the great solace that Milo brought to Hannah; taking her out of the house on walks; occupying her in caring for him and leading her to engage with other dog owners. This was possible due to the support Brookhaven provided in taking on this extra responsibility. The disclosure of Whatsapp messages from staff from Brookhaven caring for Hannah, (which was disclosed as a result of oral evidence during the inquest) reveals the care, concern and compassion of those caring for her. Their celebration of positive progress in her life in messages between them

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 Hannah's death, and in fact I note only positive support.

55. I find that Ms Lucas' email of the evening of 13th September 2023, noting "initial indicators of a deterioration" evidences careful attention to Hannah's welfare in flagging up early concerns. I agree with Dr Mynors-Wallis' evidence that this was not a red flag of imminent danger, and his view that; "I wouldn't have predicated that there would have been a very serious self-harm event from that letter". 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, in terms of Hannah's presenting condition that day or her ability to order online and take delivery at home of [redacted].

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 by Social Services in terms of Hannah's progress which became apparent during evidence by Ms Bocean, Hannah's Social Worker. She stated this was in part due to the demands on the service and prioritising those clients who did not have the support available to Hannah and therefore needed more direct contact from Social Services. Records should however be kept updated, and this is a matter I expect Surrey County Council to follow up on to ensure this occurs in the future.

Carriage of Methylene Blue in Ambulances

58. Part of the scope of this inquest was to consider training of emergency care professionals to respond to suspected [redacted]; the availability of methylene blue (or any other treatment) as an antidote, and whether the failure to administer this to Hannah more than minimally contributed to Hannah's death. I turn now to the evidence heard and my findings in this respect.

59. Professor Richard Lyons, Consultant in Emergency Medicine and Prehospital Medication and the Court appointed Expert, gave an opinion in his written report

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 that Hannah's condition was known to those treating her; that they had access to methylene blue and they were able to administer it prior to cardiac arrest occurring.

61. Professor Lyons accepted that in reality, it was not known, and could not have been surmised in the circumstances, that Hannah had consumed [redacted]. The only information available to her support staff, and therefore provided to attending ambulance staff, was that she had taken an unspecified overdose. Her presenting condition of cyanosis, struggling to breathe, was in keeping with many other medical conditions or overdose.

62. Diagnosis of [redacted] toxicity requires a blood analysis to check for methaemoglobinaemia, or via other equipment which are not carried on ambulances. Professor Lyons stated he would not have expected even frontline paramedics to be able to identify [redacted] poisoning, as this does not form part of their training.

63. Neither methylene blue, nor any other antidote to [redacted], are carried by ambulances as part of their standard drug medications. In addition, Hannah's decline was very fast; having lost conscious by the time of arrival of the first ambulance at 14.59, 12 minutes after the call was made. By the time an experienced critical care paramedic was on scene at 15.39, Hannah was already in cardiac arrest (from 15.35). Professor Lyons gave clear evidence that once cardiac arrest has occurred, the body is in cardiovascular collapse with irreversible hypoxaemia, rendering the chance of recovery at that stage incredibly slim.

64. Whilst methylene blue re-oxygenises the blood, Professor Lyon described the process to administer this as time consuming. It requires fairly large doses, with a normal sized adult requiring 4 or 5 vials to be given slowly in a dextrose infusion. In the Emergency Department scenario, it would usually require several nurses to prepare and drawer this up for administration intravenously. Hannah's deterioration into cardiac arrest occurred very quickly, giving limited opportunity for effective treatment even had her condition been known.

65. I therefore do not find on the evidence that there was any prospect of Hannah's 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 responders and paramedics. In reviewing this, in addition to Professor Lyon's 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 detailed in Dr Cowburn's evidence on behalf of the National Ambulance Resilience Unit, and that the feedback from a recent clinical subgroup meeting has been positive for further trials.

70. I accept that the expertise and equipment needed to diagnose [redacted] toxicity and administer methylene blue means this would not be possible to convey on non-specialist ambulances. Methylene blue itself is costly, with a short shelf life. The additional training for staff to recognize and treat [redacted] ingestion would not be proportionate to the number of patients that present with this, nor would the treatment required be viable for ambulance staff below the level of critical care paramedics to undertake.

71. I note that whilst it may be possible for specialist HART units and critical care paramedics to consider carrying methylene blue, the diagnostic issues remain a difficulty outside the Hospital setting, as does the time required to administer this. In addition, Dr Cowburn gave evidence that HART units are strategically based in geographical locations where they are likely to be most needed in emergencies, and therefore ability to attend in time to render assistance would also depend on location and competing demand.

72. The identification of HART units as best placed to treat [redacted] toxicity relies upon their specialist skills and training, as responders to high risk and complex emergency situations. I accept that it may only be viable for such specialist units to carry methylene blue. This is a decision to be made by each Ambulance Trust, weighing up how best to utilize their resources, and the demand for this drug against other specialist medication, with limited onboard storage space. I am satisfied from the extensive evidence provided in this inquest that this is firmly on the radar of those responsible for this decision making, and under active and ongoing review. The approach of considering this firstly via HART units, and then potentially involving Critical Care Paramedics if deemed appropriate in light of those trials seems pragmatic and sensible.

73. Dr Walker clarified that recent expert opinion from the National Poisons Information Service regarding the carriage of methylene blue by ambulances advised this was not recommended at this stage, albeit more studies and evidence are required. The advice for suspected [redacted] toxicity in the community was for management of airways, administration of supplemental oxygen, and prompt transfer to Hospital, where diagnosis and treatment can most effectively be provided.

74. In respect of SECAmb, Dr Nelson stated that [redacted] toxicity has not been an issue which has come across the radar of the Trust, but future decision making in terms of staff training, and consideration of specialist units carrying the antidote would be reviewed if required. I accept that these are decisions which

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, I heard evidence on behalf of the Home Office, from Shaun Hipgrave, Director of Protect and Prepare. The Home Office, in addition to the Department of Health and Social Care, has been the recipient of a number of previous Prevention of Future Death reports (at least five since 2020 as per Ms Bajwa's submissions) regarding the availability of [redacted] to members of the public. The responses to these reports have given reassurance that this matter is under active review by the Home Office, whereas in this inquest, it has been clarified that the Home Office is not responsible for regulation of [redacted] under the Poisons Act outside the narrow remit of countering terrorism.

77. Therefore, there is a lack of clarity regarding which Government department is best placed to consider the regulation of [redacted] to the general public, with reference to the Department of Health and Social Care, within the remit of suicide prevention policy and mental health support, or even the Food Standards Agency in considering what purity of these substances is necessary to fulfil their legitimate uses in relation to [redacted]

78. Mr Hipgrave detailed that [redacted] are both reportable substances under the Poisons Act 1972; [redacted] As such, both are available to members of the public without the need for a licence, but an obligation is placed on suppliers to make suspicious transaction reports to the Home Office when it is believed the sale is for illicit use.

79. Mr Hipgrave explained that the remit of the Poisons Act is to prevent substances being used in criminal acts, and specifically in the case of [redacted] in terrorist activity. He detailed that the use of these substances by individuals as a means of effecting suicide falls outside the remit of the Home Office, since suicide is not a criminal offence. Instead, this would fall under the remit of the Department for Health and Social Care under their policy responsibility in the prevention of suicide. He also referred to the need to balance the legitimate use of this substance by members of the public, for example in [redacted], against the risk of use for self-harm.

[redacted]When Hannah was asked further questions surrounding her proposed use of [redacted] by an English-based company, [redacted] via completion of a Declaration of Use form, she did not proceed with this order. Within the form Hannah was asked to complete, it asked for "Reference of Authorisation/ License/Registration", and Mr Hipgrave confirmed that [redacted].

81. Whilst the evidence before the Court repeated the difficulties in obtaining accurate figures for the use of [redacted] in self-harm, the anecdotal evidence of Professor Lyons and Dr Cowburn was that numbers remain small, but are increasing. I accept Professor Lyons' evidence that it remains a very small proportion of overdose cases, but that as cases are rising, monitoring of these cases and consideration of how to reduce them is required.

82. Whilst there is a legitimate use for these substances – and indeed Dr Cowburn gave evidence that he uses [redacted] – I note the purity and quantity of [redacted] and their resultant potential fatality. [redacted]

83. Counsel for the Family referred in her questions to a much lower purity being required in the legitimate use of [redacted], and the potential addition of emetic substances if taken in excess to reduce the risk of overdose. There is no evidence before the Court in relation to these factors, and indeed they fall outside the scope of this inquest, but they evidence that there is room for further exploration as to safeguarding the availability of [redacted] on the open market. These were factors Mr Hipgrave was unable to respond

further to and which do not appear to have been considered by the Home Office. It is not known whether they are being considered by any other Government Departments.

84. Whilst Border Force have recently been involved in the seizure (and subsequent release) of [redacted], Mr Hipgrave gave evidence that this can only occur when they are made aware of specific cases of importation with the suspected objective of self-harm. Otherwise, there is nothing to prevent the importation of [redacted], or the sale of this domestically.

85. Therefore at present, the onus is on the supplier to check the intended use of the recipient. Sadly, it is clear that whilst this was implemented by both companies Hannah attempted to purchase [redacted] from, it only deterred her in respect of the English company [redacted] It is not clear where Hannah obtained the information to state she required the [redacted] when responding to the [redacted] company, but clearly this was sufficient to satisfy that requirement.

86. Clearly the [redacted] Hannah purchased was the direct cause of her death. Equally clearly, there is nothing to restrict the sale of [redacted] to individuals, other than an obligation to report suspicious transactions involving reportable substances (which includes [redacted]), if there are reasonable grounds for suspecting it is intended for any illicit use. This can only be enforced against domestic sellers.

87. The question as to whether these substances should be further regulated is a policy decision, and I appreciate that this will require careful consideration as to the balance between the illegitimate use of these substances for self-harm, against the legitimate uses such as [redacted]. I accept the Home Office's submission that this would require a detailed review, including for example whether the purity can be reduced in its legitimate use and therefore legitimate sale. I also note the Home Office's submission that this does fall within the remit of the Home Office, given the lack of evidence [redacted]

88. I appreciate the evidence of Dr Mynors-Wallis that suicide prevention work and mental health treatment is not the only way to reduce the risks of self-harm, but

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

90. Submissions on behalf of the Family ask me to consider issuing a Prevention of Future Death reports in respect of other entities, and I have considered and will respond to these as follows:

SECAMB, JRCALC and/or NASMed

91. As previously outlined, I am satisfied that extensive consideration has been and is being given to the carriage of methylene blue in HART vehicles, and that it has also been considered in non-HART ambulances, including by Critical Care Paramedics. I do not believe a Prevention of Future Death report is required in this respect.

NHS Pathways/NPIS

92. I note the evidence of Dr Alison Walker, Dr Philip Cowburn and Professor Lyons, regarding the importance of identifying [redacted] toxicity in providing

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. Family refer to the lack of record keeping by Hannah's Social Worker as a PFD matter. I appreciate the concern that much of the evidence given by Ms Bocean was not recorded in Hannah's notes. However, I also appreciate Ms Bocean's 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.

SABP

95. Prevention of Future Deaths issues were identified in respect of Hannah's care during the course of this inquest, as I have detailed, and I will consider whether a PFD report is required after hearing further evidence from the Trust later today.

Others

96. I do not consider any further PFDs reports are required following this inquest. In particular, I note the submission on behalf of the Family that there should be a PFD report in relation to the need for national data on the issue of monitoring and collection of data in relation to foreign supplies of [redacted] poisonings and death. It is proposed that this should be raised to the Home Office, Department of Health and Social Care, NHS England, JRCALC and the National Police Chiefs Council. I have already outlined that I think this should properly be raised to the Home Office and Department of Social Care in their onward consideration as to whether the supply of [redacted] should be limited to the general public. I believe that is the correct approach.

97. I note also the suggestion Brookwood Care should provide training to staff regarding [redacted] ingestion. However, on the evidence before me,

staff were aware of the need to try and identify the substance that had been taken, making efforts to obtain this information from Hannah and search for any packaging, which is the key point in obtaining treatment as promptly as possible in this scenario. I do not believe further specific training is required.

98. I am also asked to consider DC Sophie Schwartz's statement that she is not aware of the police ability to conducted welfare checks where the police are notified that an individual is obtaining [redacted] as a PFD issue. This is not a matter that was explored during the course of this inquest, and there is not sufficient evidence before the Court to suggest this is an issue requiring a PFD.

Article 2

99. Finally, I turn to consideration as to whether Article 2 is engaged for the purpose of this inquest, having previously given indication that I did not find it was engaged on the evidence before the Court, but that I would keep this under review during the course of the inquest.

100. Final submissions on behalf of the Family do not seek to renew submissions in relation to the engagement of Article 2 in its operational limb in relation to Surrey County Council or SABP, and I have not found that Article 2 should be engaged in that respect. Applying the Osman duty, Hannah was always at high risk of suicide. At the time of her death, whilst Hannah showed early signs of a deterioration in her mental health, this did not equate to a real and immediate risk of death from a cause of which either SCC or SABP was or ought to have been aware. At the time of her death, Hannah was not detained under section of the Mental Health Act, and not did I find that this was indicated. Whilst I have found that there were omissions in record keeping and in some aspects of Hannah's care, I did not find that these contributed more than minimally to her death, and her presentation at the time of her death was not such that it indicated an immediate risk of death.

101. I turn then to the Family submissions in respect of the systems duty, i.e. the obligation on the state to protect life by putting in place *"a legislative and administrative framework designed to provide effective deterrence against threats to the right to life".* They refer to the number of Prevention of Future Death reports issued to a variety of state bodies in relation to [redacted] as evidence the state has been on notice that this is an increasing issue but has failed to take steps

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

102. I sympathise with the Family's position, particularly given the evidence of the 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 Jonathan Shaw, that "the Home Office is actively exploring legislative and policy options, including working with or alongside officials of other Government Departments as appropriate", 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 concern. However, I cannot find that steps should have been taken in this respect which would have prevented Hannah's death, or even "that would have increased the possibility of identifying and remedying the failures which were responsible for death" (*Cevrioglu*, as per submissions on behalf the Family*)*. I cannot find that there have been failures given the legitimate uses of [redacted] and the consideration as to whether access should be limited, and if so, how this could be effected.

105. As I have previously indicated, a Prevention of Future Death report will be issued to again highlight the need for consideration as to whether access to [redacted] should be limited, but this would be a policy decision and not one that I could determine should be made. Therefore, I cannot find measures to limit access to [redacted] should have been in place at the time of Hannah's death, and so that the absence of these was causative in Hannah's death. These are considerations which require detailed analysis and review, and I cannot find that the outcome of this will be the introduction of steps which could have prevented Hannah's death. I therefore do not find that Article 2 was engaged for the purpose of this inquest.

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 with the Family's submission to include Autism, ADHD, and anxiety and depression 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 not include "an eating disorder" as 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 Hannah's death, but around the same time she would have ordered the [redacted], and Hannah left this book on her bed where it was located by Police following her death. She ingested the [redacted] shortly after she received this; she hid the packaging in a drawer under other items; and she refused to give any information to her support staff or the call handler from SECAmb regarding what she had taken. I do not therefore view this as a cry for help given the planned nature of the overdose and the lack of disclosure to attempt to obtain appropriate treatment. I am satisfied that Hannah sadly intended to take her own life and took steps to do so. I will therefore record the following in the Record:

Box 1:
Hannah Mary Aitken
Box 2:
1a) [redacted] Toxicity
2. Autism, ADHD, anxiety and depression

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 had obtained online with the intention of ending her life from a company based in Malaysia. Miss Aitken confirmed with the company by email on 30th August 2023 that she intended to use this for [redacted]. The substance was recorded as delivered on the afternoon of 14th September. Miss Aitken was subsequently heard to call out to her support workers for help, stating she had taken an overdose. She would not provide details of the substance and had hidden the packaging. She became unresponsive and subsequently suffered cardiac arrest, from which she could not be resuscitated despite prompt attendance and efforts from South East Coast Ambulance.

Miss Aitken had a long-standing mental health background of autism spectrum disorder and attention deficit hyperactivity disorder, requiring extensive periods of inpatient admission, and was under the care of the Tandridge Community Mental Health Recovery Service, Surrey and Borders Partnership. Miss Aitken detailed an intention to end her life in a notebook, which was written some weeks prior to her death at around the time of ordering the substance. This was located on her bed after her death.

Box 4
Suicide.

I would like to express my thanks to counsel for their work and assistance, and to all who have assisted in bringing the inquest to a conclusion. I would particularly like to acknowledge the huge amount of time and effort Hannah's Family have invested in seeking to reduce the risk to others of future deaths occurring in circumstances similar to those faced by Hannah, and for their composure throughout the inquest process. I offer my very sincere condolences to them and to all those touched by Hannah's life and tragic death.

Anna Loxton, Assistant Coroner
7th November 2024