Regulation 28: Prevention of Future Deaths report

Chentoori Chanthirakumar (died 30.07.15)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Dean for Education** **Barts and the London School of Medicine and Dentistry** **Queen Mary University of London** **Mile End Road** **London E1 4NS** **2. [redacted]** **Medical Director** **East London NHS Foundation Trust** **Trust Headquarters** **9 Alie Street** **London E1 8DE**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 31 July 2015 I commenced an investigation into the death of Chentoori Chanthirakumar, aged 24. The investigation concluded at the end of the inquest on 27 January 2016. I made a determination of death by suicide, when this young woman hanged herself at home on the night of 29-30 July 2015.

4	**CIRCUMSTANCES OF THE DEATH** Ms Chanthirakumar was a fourth year medical student at Barts and the London who became acutely mentally unwell in the early part 2015. She was admitted to Mile End Hospital on 16 June 2015 via the emergency unit, and then spent three weeks in Crisis House before being discharged with follow up. Following her attendance at the emergency unit, the medical school also became involved in supporting her emotionally. They then sent an email to her on 29 July 2015, informing her that she would not be able to take her examinations in August 2015, but would be able to re-take the year.
5	**CORONER'S CONCERNS** During the course of 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. **Barts and the London** 1. Whilst it was clear to me from the evidence I heard at inquest that Barts and the London, both in terms of certain individuals within it and as an organisation, took its pastoral responsibilities very seriously indeed and made great efforts to support this student, there was one aspect of their processes that I think would benefit from review. The decision that Ms Chanthirakumar could re-take the fourth year of her medical degree was seen by the medical school as a helpful decision. The re-take was allowed on the basis of her ill health and was not a criticism of her academic achievement. That she would not be able to take her fourth year examinations in August 2015 came to be regarded as almost self evident, because she had not been able to attend the majority of her recent clinical placement and had been so recently so unwell. However, unbeknown to the university staff, Ms Chanthirakumar appears to have lacked some insight at this point, and was actually hoping not to have to re-take the year, but instead to take her fourth year exams in August 2015.

	Given the very particular course of very recent events leading up to the medical school's decision, I wonder whether a personal meeting to discuss matters with her could have been arranged, rather than communicating this by email. A face to face meeting may not necessarily have had any impact on the outcome, but nevertheless I think would be a helpful consideration for the process in the future. **East London Trust** 2. After the medical school was alerted to Ms Chanthirakumar's illness by two of her friends on 17 June 2015, a senior lecturer working in student support services (and, as it happens, herself a general practitioner) rang Globe Ward of Mile End Hospital and spoke to a treating nurse. Her intention in making this call was to deliver information, most specifically to relay concerns that Ms Chanthirakumar was not being wholly open with staff about the extent of her distress. However, such was the ward nurse's anxiety not to breach patient confidentiality, the conversation was not as meaningful or as productive as it might otherwise have been. It seems to me that nurses and doctors working in mental health particularly, would benefit from a reminder of the difference between absorbing (and, if appropriate, acting upon) concerns raised by a patient's relatives, friends, tutors etc., and divulging a patient's private details. In addition, it may well be that a piece of self reflection has already been undertaken by the mental health team caring for Ms Chanthirakumar, taking into account the fact that she took her own life so soon after her discharge from a period of inpatient treatment, and with her university being unaware of her own expectation that she would be able to take her exams in August 2015. It seems that such reflection might usefully inform future practice.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and your organisations 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, by 11 April 2016. 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] parents of Chentoori Chanthirakumar 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 05.02.16