Eastern Area of Greater London Coroners
MISS N PERSAUD
SENIOR CORONER
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REF:6555

27th March 2018

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr John Brouder, Chief Executive, North East London Foundation Trust** [redacted] **Practice Manager, Fullwell Cross Medical Centre**
1	**CORONER** I am Miss N Persaud Senior Coroner for **Eastern Area of Greater London**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 18/07/2017, I commenced an investigation into the death of Maureen Anne CAMPBELL-SCOTT. The investigation concluded at the end of the inquest 26th March 2018. The conclusion of the inquest was a narrative conclusion: *Maureen Campbell-Scott suffered fatal injuries when she fell from the ledge of the Exchange Shopping Centre. She died as a result of her own actions, but the evidence does not reveal her intention at the time of the fall.*
4	**CIRCUMSTANCES OF THE DEATH** Maureen Campbell-Scott had suffered for many years from depression and anxiety. She suffered a decline in her mental state in around April 2016. The GP referred her to the mental health services on 29 April 2016. There was a delay in the correct team processing the referral. She was assessed by the older age mental health team in September 2016, but was not considered to meet the criteria for specialist mental health services at that time. She came under the care of the specialist mental health services in November 2016 following her husband's contact with Mental Health Direct. She remained under the care of the specialist mental health services until she passed away. Medication that she had remained stable on for many years, appeared no longer to be working for her. Her medication regime was therefore changed by her consultant psychiatrist. There were some delays in communicating requested medication changes to the GP. Directions provided by the mental health team to the GP, in relation to prescription of mental health medication were not fully complied with. It is not

	possible to determine whether the poor prescribing and delayed communication contributed to her death. On the 16 June 2017, Maureen climbed over the wall of the Exchange Shopping Centre car park and lay down on a ledge which was approximately fifty feet high. She had placed a plastic bag over her head. When a member of the public and members of staff from the shopping centre attempted to help her, she was seen to roll off the ledge. She died as a result of multiple injuries. Her life was pronounced extinct by a paramedic on scene at 20.19 on 16 June 2017.
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: (1) The GP had sent the referral to the wrong team of the mental health trust. The referral then got lost between the receiving team and the correct team (the older age mental health team). This resulted in a 4 month delay in Maureen Campbell-Scott receiving an assessment. (2) There were often delays (in excess of 14 days) in the delivery to the GP of clinic letters from the mental health trust. Often, the clinic letters contained requests for the GP to make changes to medication. (3) The prescribing by the GP did not always follow the direction given by the psychiatric team. (4) In times of acute mental health crisis, medication is often rapidly changed/supplemented. Mrs Campbell-Scott had 7 changes in her medication regime between 21 November 2016 to 23 February 2017. It is challenging for GPs to be able to ensure rapid and accurate changes when medication changes are directed by the specialist team. (5) At the time of the Inquest hearing, there had been no joint meeting between the mental health trust and the GP practice to consider the best way forward in terms of referrals to the service; prescribing during times of dynamic medication changes and general communication between the GP and the psychiatrist. (6) It is accepted that the concerns in this case are unlikely to be restricted to the Fullwell Cross Surgery. If a joint protocol is agreed between the Trust and the Practice, this could be shared more widely with other practices.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 23 May 2018. 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] [redacted](son). I have also sent it to Mathew Cole (Director of Public Health) and to the CQC, who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. I will also forward your response to those listed above. 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	27/03/2018 Signature Miss N Persaud Senior Coroner **Eastern Area of Greater London**