IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Ernest Wayne Smith
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** • Fiona Edwards Chief Executive Surrey and Borders Partnership NHS Foundation Trust 18 Mole Business Park Leatherhead Surrey KT22 7AD
2	**CORONER** Ms Anna Crawford, HM Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INVESTIGATION and INQUEST** An inquest into the death of **Ernest Smith** was opened on 22 June 2016. It was resumed and concluded on 13 December 2017. The medical cause of death was found to be: 1a. Hanging The inquest concluded with a short form conclusion of 'Suicide'.
5	**CIRCUMSTANCES OF THE DEATH** On 13 June 2016 Mr Smith was found deceased in an area of woodland at Chelsham Common in Warlingham. In 2011 Mr Smith had been diagnosed with depression and begun on

anti-depressants by his GP, [redacted] of Elizabeth House Medical Practice, Warlingham.

In April 2015 Mr Smith was referred to the Tandridge Community Mental Health Recovery Service (CMHRS) at Langley House in Oxted, which is part of Surrey and Borders Partnership NHS Foundation Trust (SABP).

In June 2015 Mr Smith was referred to [redacted], a Senior Clinical Psychologist at the CMHRS who saw him from August 2015 to May 2016. Mr Smith was also referred to the Enabling Independence Service and was provided with a Care Co-ordinator, but he did not engage with either.

Mr Smith's GP remained responsible for prescribing his anti-depressant medication and continued to see Mr Smith regularly. [redacted] gave evidence that she was concerned that he was not improving despite an increase to his anti-depressant medication.

On 31 July 2015 she contacted the CMHRS and requested that he be seen by a psychiatrist to review his medication. A medical review was arranged on 20 August 2015 but Mr Smith did not attend. [redacted] was not informed that Mr Smith had been offered an appointment, or that he had not attended, and Mr Smith was not offered a further appointment, in contravention of the standard procedures in place at the time.

From March 2016 onward [redacted] gave evidence that she had noticed a significant decline in Mr Smith's presentation.

On 7 March 2016 she wrote to the CMHRS describing the deterioration and requesting a medication review. The court heard evidence that Dr Parry's letter was considered at an Allocation Meeting on 15 March 2016, but did not result in a medical review. [redacted], the team's Consultant Psychiatrist, accepted that Mr Smith ought to have been offered a medical review at that time but it was not possible to establish why it had not happened.

On 16 May 2016 [redacted] telephoned [redacted] directly and asked him to make an appointment for Mr Smith. [redacted] agreed to do so but the appointment was not made prior to his death. It was not possible to establish exactly why the appointment was not made but it was most likely as the result of administrative error.

	[redacted] gave evidence that she was not informed about numerous instances when Mr Smith either did not attend or cancelled appointments with [redacted], the Enabling Independence Service or his Care Co-ordinator.
6	**CORONER'S CONCERNS** Following Mr Smith's death a Root Cause Analysis investigation was conducted by the Trust and the court was told that a number of changes have been introduced and that further training has been provided. However, there remain two broad areas of concern. The **MATTERS OF CONCERN** are: - The system for considering correspondence received from GPs, including requests for medication reviews, appears to remain the same as the system which was in place at the time of Mr Smith's death and which failed to identify [redacted] request for a medical review on 7 March 2016. - There are a number of CMHRS service users who, like Mr Smith, are not under the CMHRS medical team, but whose care is led by other members of the multi-disciplinary team, including clinical psychologists and care co-ordinators. The court heard that there is a clear system in place in the medical team for updating GPs on progress and also in the event of failures to attend appointments (DNAs). However, it did not appear to the court that there was a clear system for updating GPs when the medical team was not involved in a patient's care. This risks GPs being unaware, as [redacted] was in this inquest, of instances in which their patient begins to display signs of disengagement with the service. Consideration should be given to whether any steps can be taken to address the above concerns.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

	Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following: 1. [redacted] 2. [redacted], Elizabeth House Medical Practice 3. Care Quality Commission 4. The Chief Coroner In addition to this report, I am 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.
	Signed: **ANNA CRAWFORD** **DATED this 14 day of December 2017**