REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive of Kent and Medway NHS and Social Care Partnership Trust
1	**CORONER** I am Briony Ballard, Assistant Coroner, for the coroner area of Inner London South
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.
3	**INVESTIGATION and INQUEST** On 30 November 2017 this jurisdiction commenced an investigation into the death of Rebecca Marshall. The investigation concluded at the end of the inquest on 27 August 2019. The conclusion of the inquest was that Miss Marshall died as a result of suicide.
4	**CIRCUMSTANCES OF THE DEATH** In March 2017, Miss Marshall whose home address was within the Kent area was referred for an mental health assessment in Maidstone, Kent to manage her escalating self-harm, depression, anxiety and angry outbursts. Despite the subsequent primary mental health assessment identifying the need for a full diagnostic secondary mental health assessment and despite two periods of crisis at the end of July 2017 and the beginning of September 2017, no such assessment was forthcoming. In about October 2017, Miss Marshall started her university degree at Goldsmiths University, London and accordingly began residing in university halls of residence. She had a further period of crisis and saw a local London based GP who referred her to the community mental health team under the South London and Maudsley NHS Foundation Trust (SLaM). At the same time she sought to and was accepted onto the University's counselling service. The assessment by secondary services from Kent Medway NHS and Social Care Partnership Trust (KMPT) which had been requested much earlier in the year eventually did take place in November 2017. However, this was only a routine medication review at which it was concluded because Miss Marshall was reporting she was under a London based GP and community mental health care team there was no need for any further input and she was discharged to the care of her London based GP. There was no interagency communication between staff employed by KMPT and / or SLaM. Despite urgent referrals being made when there was a further deterioration later in November 2017 no senior review was arranged. Miss Marshall was discovered deceased in her room on 27 November 2017 after the alarm was raised by her father.
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) At inquest I was told that both Trusts involved: SLaM and KMPT had investigated the circumstances of Miss Marshall's death independently. (2) At a pre-inquest review hearing on 18 October 2018 I suggested that in light of the circumstances of the case it would be preferable for a joint report to be produced focussing on the apparent lack of interagency communication which had apparently led to Miss Marshall not being reviewed as required. (3) At inquest I was told that following the pre-inquest review hearing there had been a meeting between the two Trust's and that the report from KMPT would be exhibited to and form part of the report of SLaM Trust. (4) Both reports identified a number of missed opportunities in Miss Marshall's care, including steps to ensure joint ownership of her care when she became a student in London. (5) I was told at inquest of the lessons learnt by both Trusts and the actions completed. (6) From what I was told at inquest however, it appeared that KMPT had not taken any steps to address the issues of obtaining collateral information from or sharing information with other Trusts involved in the care of one of their patients, particularly if they have moved, permanently or temporarily to / from KMPTs area. (7) Miss Marshall formed part of what could be considered to be a particularly vulnerable group of individuals, namely a member of the student population suffering from mental health challenges whose continuity of care could not be guaranteed by good inter Trust communication.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 13 November 2019. 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] the deceased's father, SLaM NHS Foundation Trust, [redacted] RMN within KMPT, and [redacted] Speciality Doctor. 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 coroner, at the time of your

	response, about the release or the publication of your response by the Chief Coroner.
9	24 September 2019 Briony Ballard **[DATE]** **[SIGNED BY CORONER]**