IN THE WEST LONDON CORONER'S COURT

INQUEST into the death Of Bathsheba Shepherd

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Central and North West London NHS Foundation Trust** **2. Sir Simon Stevens, Chief Executive of NHS England**
1	**CORONER** I am Dr Séan Cummings Assistant Coroner for the Coroner Area of London (Western Area)
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 the 1st December 2015 I commenced an Investigation into the death of Bathsheba Shepherd, known as Kay to her family, who was pronounced deceased at [redacted] Uxbridge on the 11th November 2015 after being fatally stabbed by her housemate, [redacted], at some point between the 10th and 11th November 2015. I heard evidence over nine days and concluded the Investigation and Inquest on the 11th September 2020.

4	**CIRCUMSTANCES OF THE DEATH**

1. Bathsheba Bianca Kay Shepherd and [redacted] were both extremely vulnerable individuals housed together in a house with two bedrooms, one living room and kitchen and one bathroom. The boiler, source of much tension, was in Kay's bedroom. There were problems with the heating and hot water system which caused escalating tension between the parties.
2. [redacted] was a young man with paranoid schizophrenia and a cannabis or skunk dependence. Cannabis has potential to make paranoid schizophrenia worse and also to interrupt compliance with medication compounding the paranoia and psychiatric disturbance. He was an aggressive young man whose aggression magnified around availability or otherwise of cannabis.
3. Kay was a vulnerable middle aged woman who although judged to be in high need and was living in accommodation with visiting support workers did not have contemporaneous mental health involvement and did not have a GP or social worker or care coordinator. She did not have a GP partly at least because she needed ID to do that and she declined to apply for a passport on the ground of cost. The failure to have a GP meant that the source of any medication supply for her epilepsy was uncertain and I feel that it was overwhelmingly likely that she wasn't being treated at all for her epilepsy. Not being treated put her at risk of physical injury occasioned through any fits and amounted to a significant gap in care and support offered. Not having a GP represented a missed opportunity to intervene in terms of her mental health. In my view a much more assertive approach to this was required to ensure she was registered but it appears that without formal identification GP practices will not register individuals.
4. Kay was living at [redacted] first. [redacted] had spent 19 months in a psychiatric facility before being deemed suitable for graduation into the community. [redacted] was referred to the Accommodation Panel. A Care Programme Approach review occurred whilst he was an inpatient on the 6th January 2015. Following that his case was presented to the

Accommodation Panel on the 30th January 2015. My attention was drawn to the fact that even though [redacted] was an inpatient on the ward for 15 months neither a full psycho social assessment was undertaken nor a NHS and Community Care Acts needs assessment. I was told that this is an important element in identifying a patient's needs and also informs overall risk management.

5. Once approved by the Accommodation Panel [redacted] was assessed by a Senior Support Worker. She had access to the referral form but did not enquire as to the history of aggression and did not seek elaboration or corroboration before approving the onward referral to the landlord. She said in evidence that she had not come across a mixed sex housing proposition before. She was aware of [redacted] circumstances and those of Kay. Despite this she approved the placement. This was an error.
6. There is no documentary evidence of Kay being asked as to her views on [redacted] moving in but I note that initially things went well between them.
7. There was clear and repeated evidence during [redacted] stay in hospital between 31st July and 24th August 2015 of his distress at his living arrangements and that he posed a threat to Kay's physical safety. Despite this I gained the distinct impression that staff were more concerned about risks posed to them than those posed to Kay. Indeed, Kay and her safety and security do not feature in the discussions or plans to ensure safety. It was as if she was not there.
8. The perfunctory discharge of [redacted] on the 24th August 2015 represents a serious error on the part of the relevant clinicians and in my view contributed significantly to the risk Kay ultimately faced. That was compounded by the HTT discharging him to EIS leaving EIS scrambling to catch up and provide some level of care, which to the team's credit they managed.
9. The failure to expeditiously rehouse [redacted] and to effectively risk assess him and manage those risks in the time between discharge from hospital and Kay's death meant that she

	was living with and ultimately killed by an extremely dangerous young man who had himself recognized that he should not return to [redacted] and had expressed his dislike of his flat mate to clinicians and asked to be placed elsewhere.
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 could 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) I was concerned to find that even though 5 years had elapsed between Kay's death and the hearing of the Inquest the issue of the way in which the Care Programme Approach was being conducted between the local authority and the NHS Trust was still the subject of discussion and had not been resolved to the satisfaction of the manager responsible for the process. The delay in my view represents a threat to the lives of others in similar situations. (2) I was concerned by evidence in the course of the Inquest that the disengagement of a person with known psychological illness from the process of registration with a GP by her failure to obtain relevant documentary proof to enable registration meant that she could not be registered. Registration with a regular GP would in my mind have provided additional support to her. This may have enabled her to raise concerns or fears relating to her accommodation and housemate.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (1) [redacted], The Chief Executive of the Central and north West London NHS Foundation Trust and you, (2) [redacted], Chief Executive of NHS England 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 24rd May 2021. 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 (1) The Shepherd Family, (2) [redacted] The Chief Executive of the Central and North West London NHS Foundation Trust;(3) [redacted], The Chief Executive of NHS England 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	**28th March 2021** Dr Séan Cummings Assistant Coroner London West