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

The Inquest Touching the Death of Sarah Margaret Clarke
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • **Chief Executive, Surrey University** • **Chief Executive, NHS England** • **Universities minister – Ms Donelan MP** • **Manager – CWB centre, University of Surrey**
1	CORONER Dr Karen Henderson, HM Assistant Coroner for Surrey
2	CORONER'S LEGAL POWERS I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	INVESTIGATION and INQUEST On 28th November 2019 I commenced an investigation into the death of Sarah Margaret Clarke. On the 23rd April 2021 I concluded the Investigation. The medical cause of death given was: 1a. Suspension I determined that Sarah Margaret Clarke died by suicide
4	CIRCUMSTANCES OF THE DEATH Sarah Margaret Clarke was a 23 year old final year Business Marketing degree student at Surrey University (US). She had a history of mental health concerns for which she had sought and had previously received treatment.

On the 19th November 2019 at or around 09:00hrs Sarah attended the Centre of Wellbeing (CWB) at SU as she was depressed and finding life difficult. She completed an electronic proforma and a care worker (qualified social worker with mental health experience) from the CWB contacted her by telephone at or around 11.00 am. Prior to the phone call the care worker had reviewed her previous involvement with the CWB including previous suicidal ideation and potential acts of suicide. The conversation included the following information from Sarah:

1. She had 2 S136 MHA assessments in July and August 2019
2. She had been formally admitted under S2 MHA in July 2019
3. She had been under the MH team at home until self-discharge in August 2019
4. She was formally diagnosed with bipolar disorder and/or emotionally unstable personality disorder

After a few minutes on the phone Sarah became extremely distressed and she abruptly hung up. After five minutes or so the care worker phoned Sarah back. Sarah did not answer, and the care worker left a message asking Sarah to ring back. The care worker made an appointment for Sarah to see a counsellor 2 days hence, on the 21st November 2019 and an administrator sent Sarah a generic email informing her of the appointment. No further contact was made by CWB to Sarah.

On the 21st November 2019 at or around 09:00hrs an administrator at the CWB became aware of an email sent by Sarah at or around 05:45hrs indicating that she intended to end her life. The administrator passed the email onto a mental health nurse who thought it may be a 'cry for help' and looked at her notes before requesting security to attend her accommodation at the University of Surrey (US). Sadly, Sarah was found deceased and recorded to have died by way of self-suspension in her accommodation within the US campus at 10.11hrs on 21st November 2019.

Sarah left a final note indicating her distress by what she perceived was the patronising attitude and behaviour of the care worker during the phone call on 19th November 2019. At inquest, it was recognised that the CWB administrator did not send Sarah a document requesting a personal assessment of her mental health status to assist in triage of Sarah's mental health. Furthermore, Sarah did not, as was expected, confirm she would attend the appointment and the administrator did not thereafter contact Sarah again to ensure she would be attending.

5	CORONER'S CONCERNS 1. I heard evidence students have a higher incidence of mental health difficulties, self-harm and suicide exacerbated by multifactorial issues such as being effectively itinerant with work and other social pressures. 2. Sarah was known to have significant mental health difficulties exacerbated by a recent bereavement and other personal difficulties. On 19th November 2019 after Sarah hung up on the administrator and was knowingly extremely distressed, CWB staff did not take steps to reassure themselves that Sarah was safe from self-harm. 3. The organisation and systems at the CWB were insufficiently robust to appropriately manage, treat and safeguard students known to have mental health problems and be at high risk to themselves on a background of a lack of national guidance of what are the basic requirements for universities to provide such services. 4. National guidance issued in September 2018 to reduce the incidence of suicide in the student population had not been implemented by CWB at the time of Sarah's death. 5. There was no internal (by CWB) or external regulatory (by US) oversight as to the service provision at CWB before Sarah's death or indeed after her death. 6. There was little communication or learning between and a lack of involvement sought or offered by local NHS mental health services to ensure the service provided by CWB was within an acceptable standard. 7. There was no serious incident report completed by US as to the working practices of the CWB and no reflection has taken place and no steps have been taken to put into place by CWB to provide more robust systems to confirm the safety of students such as Sarah.
6	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 have the power to take such action.
7	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. See names in paragraph 1 above 2. [redacted], Sarah's father 3. [redacted], Sarah's brother 4. Clinical director, SPFT 5. 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.
	Signed: Karen Henderson DATED this 16th Day of May 2021