ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. Chief Executive, South West London and St George's Mental Health NHS Trust** **2. NHS South West London Integrated Care Board** **3. The Rt Hon Victoria Atkins MP, Secretary of State for Health and Social Care**
1	**CORONER** I am Priya Malhotra, assistant coroner, for the coroner area of Inner West 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.
3	**INVESTIGATION and INQUEST** On 24 April 2022 an investigation commenced into the death of Juan David Martin. The investigation concluded at the end of the inquest on 10 June 2024. The conclusion of the jury was suicide.
4	**CIRCUMSTANCES OF THE DEATH** Juan Martin was diagnosed with emotionally unstable personality disorder, depression, and anxiety. He was known to have suicidal ideation and had in the past attempted suicide. On 6 April 2022 he was detained by police under s.136 of the Mental Health Act 1983 at Beachy Head, Brighton having expressed a desire to cause harm to himself; he was taken to a place of safety. On 7 April 2022 he was informally held at the Lotus Assessment Suite at Springfield Hospital, London. On 10 April 2022 he expressed a desire to leave the Lotus Assessment Suite. He was then assessed under the Mental Health Act 1983 on 11 April 2022, and subsequently liable to be detained under s.2 of the Mental Health Act 1983, pending an appropriate bed. Accordingly, Juan Martin remained at the Lotus Assessment Suite held under common law. On 12 April 2022 he was seen by staff squeezing through a door leading to the external door of the unit; he was challenged by staff, who persuaded him to return. At approximately 15:00 on 12 April 2022 a bed became available on Ward 2 but was contingent upon another patient transferring out. This did not happen. According to witnesses at approximately 17:00 a bed became available on the Jupiter ward. There is no documentary evidence confirming this. By 19:03 the fire alarm was activating on the Lotus Assessment Suite triggered by steam from a shower. There was no fire evacuation policy for those liable to be detained and accordingly Juan Martin was evacuated along with other patients to an insecure area outside the Lotus Assessment Suite. He immediately ran off and was visible on CCTV in the vicinity of the hospital for approximately up to 8 minutes after. At 01:40 on 13 April his bank card was used to make a balance enquiry followed by a cash withdrawal of £11.99. At 11:25 on 13 April 2022 members of the public reported seeing a male on the wrong side of the fence [redacted]. Local police officers attended and at 11:57 he was witnessed by police officers allowing himself to fall. Despite emergency life support provided by officers on scene, an off-duty Emergency Department doctor and paramedics Juan Martin was confirmed deceased at 12:36. The medical cause of death was: 1a. Multiple Injuries; and 1b. Impact after descent from height.

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) Juan Martin was held informally on 7 April 2022 and following a mental health assessment on 11 April subsequently became liable for detention. He therefore spent 6 days in the Lotus Assessment Suite. Witnesses confirmed that no suitable bed was identified until approximately after 15:00 on 12 April 2022, which then became unavailable. (2) The Matron in Acute and Urgent Care confirmed bed capacity remains an ongoing problem and has not been resolved. The Matron provided one recent example where a patient waited for 7 days in the Accident and Emergency Department for a mental health bed. (3) The Matron added there was an exceptional process which required a considered decision at a high level to make a bed available through identifying someone currently occupying a bed space to be discharged and that the 'flow' of patients being discharged or moving to another setting amplified the bed capacity issue. Based on the evidence heard, my principal concern is that bed capacity in London remains inadequate. Whilst some action may have been taken by the Trust to better triage the need for beds it is insufficient to resolve the problem. It follows there is a genuine risk of future deaths directly connected to a shortage of mental health bed spaces in London unless further action is taken.
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 7 August 2024. 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 Juan Martin's family. 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	**Priya Malhotra** **Assistant Coroner Inner West London** **11 June 2024**