ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Officer Surrey County Council** **2. Chief Constable Surrey Police** **3. Chief Executive Surrey and Borders Partnership**
1	**CORONER** I am Caroline Topping, assistant coroner, for the coroner area of Surrey
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 24th April 2023 an investigation into the death of Helen Jane Kerr was commenced. The investigation concluded at the end of the inquest on 7th June 2024. Helen Kerr died by hanging. The conclusion as to death was a narrative conclusion as follows: Helen Kerr went to live at in a refuge in Woking on the 2nd February 2023. She had a history of drug and alcohol abuse and was referred to I access. Her mental health deteriorated, and she developed psychosis. On the 1st March 2023 she was assessed at I access and a plan for a referral to the community health team was devised. The referral was not made because of pressure of work. On the 13th March 2023 her support worker was so concerned by her mental health that she called an ambulance and Helen was taken to St Peter's Hospital. She was seen by a nurse from the liaison psychiatry team. No collateral information was sought and the full description of her presentation from the paramedics was not seen. She was assessed as not requiring a referral to the community mental health team despite showing signs of paranoid delusions. She was discharged. Her support workers made repeated attempts to obtain mental health care for Helen contacting the single point of access, I access, the community mental health and the CRISIS line. Helen's case was not discussed with a psychiatrist and her support workers were not contacted for information by any of these organisations. On the 31st March 2023 Helen attended Surrey Police station in an extremely paranoid state and then went to St Peter's Hospital seeking an admission. She was partially assessed by liaison psychiatric nurses and offered a home treatment team assessment. She declined and was discharged by the team without collateral information being sought or the advice of an on-call psychiatrist. She needed to be admitted to hospital for a diagnosis and treatment of her mental health condition.

	She was discharged from hospital on the 2nd April 2023 and returned to the refuge. She was found dead on the morning of the 3rd April 2023 having self-ligatured. Her condition was amenable to treatment with anti-psychotic medication. The death was avoidable with appropriate treatment. She intended to take her own life. She died by suicide. The death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** See the details set out in the narrative conclusion. In addition: Prior to being placed in the refuge on the 2nd February 2023 Ms Kerr was charged with carrying a bladed article when she surrendered to bail. She told the police that she was carrying a knife for her own protection. This was known to Surrey Police and mental health services by March 2023. On the 13th March 2023 paramedics contacted the police for assistance at the refuge concerned because she was carrying a nail file for her own protection. When she attended Surrey Police station on Friday the 31st March 2023 she did so concerned for her own safety. She was extremely paranoid but was assessed not to warrant s136 detention. She left the police station saying she was going to hospital. A SCARF was written but could not be lodged before the end of the working day on the 31st March 2023. As a result, it was not processed until Monday the 3rd April 2023, after her death, because SCARF's are processed during working hours. The expert gave evidence was that she would have been very worried if she was told Ms Kerr was carrying a knife because she was having paranoid delusions that she needed to protect herself and her family. Some of Ms Kerr's paranoid delusions related to concerns about the actions refuge workers. The refuge was not contacted by the police on the 31st March 2023. The court was told that GDPR prevented the police from sharing the information about Ms Kerr with the refuge.
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. Following the conclusion of the Inquest a considerable amount of evidence has been provided by Surrey and Borders Partnership in relation to changes in procedures in relation to processing of referrals into their services. Referrals into the Single Point of Access can now be made by voluntary agencies and new protocols require more senior oversight of triaging decisions and recording of collateral information from referrers. In addition, a review of the SCARF process is being undertaken but has not yet concluded. However, I remain concerned about a number of matters: The **MATTERS OF CONCERN** are as follows. – (1) Cogent information about Ms Kerr's declining mental health was provided repeatedly

	to Surrey and Borders Partnership secondary mental health teams from the refuge support workers. It was not explored with them, and insufficient weight was given to it during the triage process. Ms Kerr was not provided with appropriate and timely referrals for mental health treatment. Despite the evidence that significant changes are being put in place the efficacy of these changes has not yet been evidenced. (2) Ms Kerr was seen at the police station and hospital in an extremely psychotic and paranoid state. Police records showed that she had been arrested and charged with carrying a bladed article. It was also recorded that she had subsequently carried a nail file, for her own protection. The officer who saw Ms Kerr on the 31st March 2023 was unable to read the records because Ms Kerr's condition meant that the officer could not leave the interview room before Ms Kerr decided to leave the station. The risk this posed to the public was therefore not considered. No action was subsequently taken in relation to the risk. (3) The SCARF process does not enable information sharing between the Police, Mental Health Agencies and Surrey Adult Safeguarding out of hours. It is under review. It remains unclear how information sharing out of hours is to be achieved in a timely fashion to safeguard individuals and the public. (4) The refuge was not made aware of Ms Kerr's presentation on the 31st March 2023 by Surrey Police. Her delusions about the actions of refuge workers could have put them in danger.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 12th November 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: Mrs Kerr's Family St Peter's Hospital The Refuge (details redacted) I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**18th September 2024 [SIGNED BY CORONER] Caroline Topping**