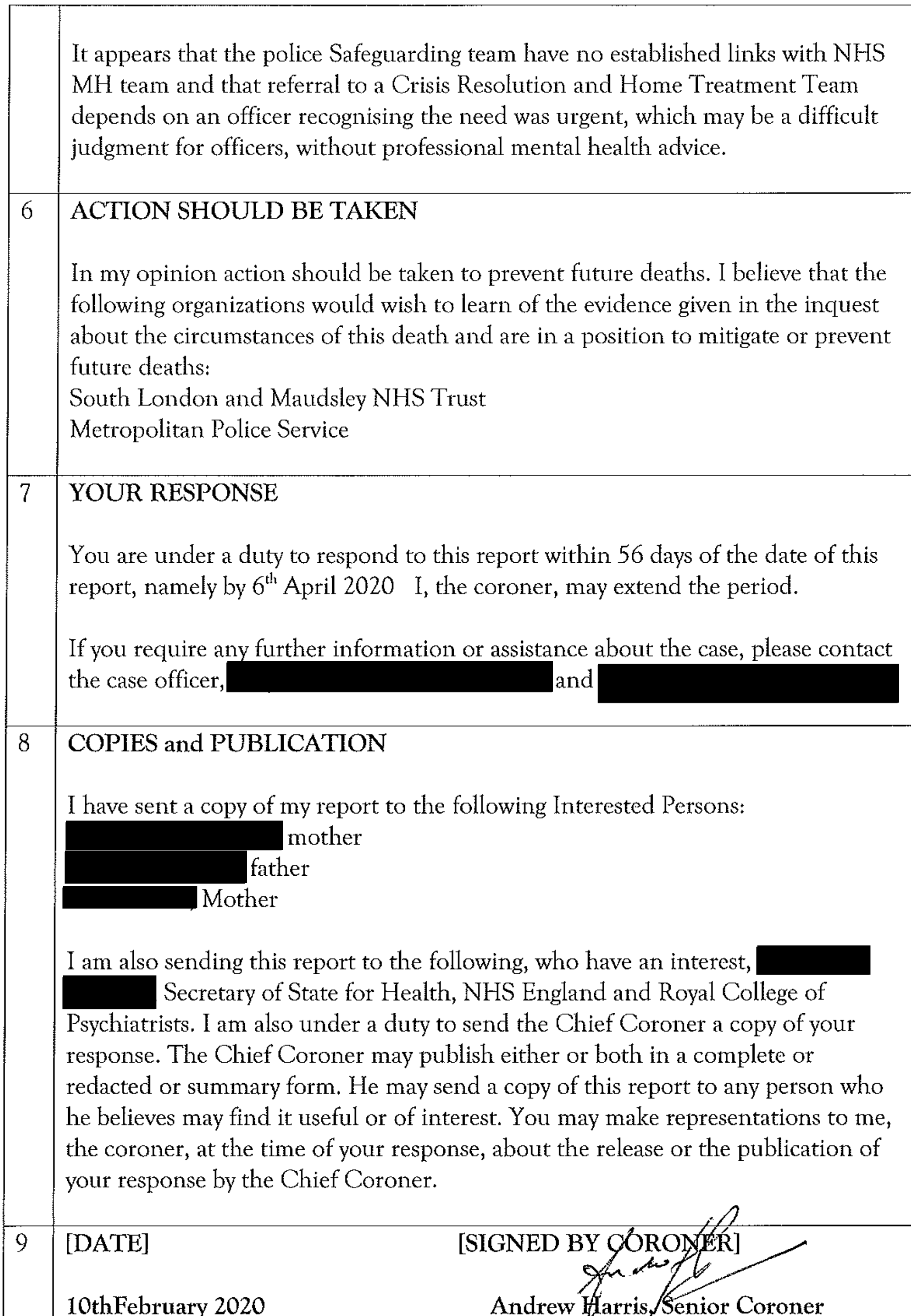
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. South London and Maudsley NHS Foundation Trust: [redacted] 2. Metropolitan Police Service: [redacted]
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** I opened an inquest into the death of Ms Kerry Aldridge, who died on 6th April 2019 at Sydenham Railway Station (00969-2019). An investigation was opened on 10.04.19 and an inquest was opened on 25th April and was concluded on 9th October 2019. A decision on whether to send a report was delayed by the process securing a transcript and awaiting interested persons to make submissions, which ultimately was not taken up. The medical cause of death was: 1a Multiple Traumatic Injuries. The conclusion was suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was a student police officer. Safeguarding officers discussed her mental well being with her on 27th March, after an allegation of a crime. On 4th April, police officers were alerted to her high risk of suicide by jumping in front of as train, and found her at a railway station and took her home and spent time with her. Two days later she returned to the station and jumped into the path of a train.
5	**CORONER'S CONCERNS** During the course of the inquest, the local MPS investigation by Directorate of Professional Standards reported the view of the Central Mental Health Team that Sexual Offences Investigation Trained officers require further training in mental health. [redacted] the investigating officer, gave evidence that it would be beneficial to have a mental health single point of contact within the local mental health team who could be contacted for non-urgent advice by Safeguarding Teams concerning victims that they are most concerned about. The investigation found no misconduct by officers, who provided a good level of care and support. The **MATTERS OF CONCERN** are as follows. -



	It appears that the police Safeguarding team have no established links with NHS MH team and that referral to a Crisis Resolution and Home Treatment Team depends on an officer recognising the need was urgent, which may be a difficult judgment for officers, without professional mental health advice.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths. I believe that the following organizations would wish to learn of the evidence given in the inquest about the circumstances of this death and are in a position to mitigate or prevent future deaths: South London and Maudsley NHS Trust Metropolitan Police Service
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th April 2020 I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the case officer, ████ and ████
8	COPIES and PUBLICATION I have sent a copy of my report to the following Interested Persons: ████ mother ████ father ████, Mother I am also sending this report to the following, who have an interest, ████ ████ Secretary of State for Health, NHS England and Royal College of Psychiatrists. 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	[DATE] [SIGNED BY CORONER] 10thFebruary 2020 Andrew Harris, Senior Coroner