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, Cumbria Partnership NHS Foundation Trust** **2. Chief Executive, Cumbria County Council**
1	**CORONER** I am Ian Smith, Senior Coroner, for the coroner area of South & East Cumbria
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 10 January 2013 I commenced an Inquest into the death of Helena Kathleen Farrell, date of birth: 20 February 1997. The investigation concluded at the end of the inquest on 30th June 2014. The conclusion of the inquest was that she died as a consequence of her own actions though her intention is not clear beyond unreasonable doubt. The cause of death was 1a. Hanging.
4	**CIRCUMSTANCES OF THE DEATH** Helena suffered from bulimia and had been assaulted sexually whilst on a school exchange visit. This occurred during 2011 and the incident probably occurred in France. During October 2012 to January 2013 a number of events occurred including that she revealed the fact she was bulimic and the fact she had been assaulted, she took an overdose, self-harmed at a party, and wrote a number of letters which when read after her death appeared to have been suicide letters. Although she was referred by the School Nurse to Child and Adult Mental Health Services (CAMHS) she was not seen until the day before she died and no-one who saw her thought that she was suicidal and everyone who had dealings with her seems to have misunderstood her true feelings and intentions.
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 will 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) As for CAMHS (part of the Foundation Trust) the referral system was not working adequately and the referral was not followed up after triage even though it was classified as urgent. (2) Staffing levels at CAMHS were inadequate in terms of pure numbers and also in terms of experience and training in connection with teenagers.

	(3) Those dealing with Helena failed to recognise the escalation of the incidents in which she was involved in terms of their seriousness and their increasing frequency. (4) As far as Cumbria County Council is concerned, they are involved because I understand they are responsible for provision of the school nurse service although they contract this out to the Partnership Trust but nonetheless the responsibility lies with Cumbria County Council. I thought that the expectations of the school nurse in this particular case were totally unrealistic. I heard in evidence that she was responsible for 5 senior schools and 20 or more feeder schools to those 5 senior schools and although the total number of pupils involved was not clear, it is obviously thousands rather than hundreds. She worked a 26 hour week, had 40 current cases at Kirkbie Kendal School alone. The provision of service at this level is totally unfair on the school nurse concerned, unrealistic in the sense that others have expectations of a school nurse which one part time provider cannot meet. (5) The school's counsellor had been in post for many years and there was no proof of her qualifications or her competence nor of update and training or registration with any professional body. The County Council needs to be more thorough with checking credentials.
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. I wish you to consider the matters set out above, to consider the Serious Untoward Incident Report compiled by the Foundation Trust, consider its recommendations and their implementation. I wish you to consider the Serious Case Review undertaken by the Safeguarding Children Board and its recommendations and to consider whether you should take action to implement those recommendations and I wish both organisations to contemplate the content and demeanour of those two reports and to consider whether in your respective roles, CAMHS and Cumbria County Council, can provide a safe environment for children to be dealt with because, sadly, this was not provided in relation to Helena.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st September. 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, [redacted] and to the Local Safeguarding Board. 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] 3 July 2014**	**[SIGNED BY CORONER] Ian Smith**