REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Rt. Hon. Nicky Morgan MP, Secretary of State for Education** **2. Rt. Hon. Lord McNally, Chair of the Youth Justice Board** **3. The Chief Constable, South Yorkshire Police** **4. Chief Executive GeoAmey** Note that the report is not addressed to the Sheffield City Council as the evidence at the inquest satisfied me that they have already dealt with the points herein so far as relevant to them.
1	**CORONER** Christopher Peter Dorries, senior coroner for the South Yorkshire (West) area.
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. (1) Where – (a) A senior coroner has been conducting an investigation under this Part into a person's death (b) Anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and (c) In the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action. (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it. (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner
3	**INVESTIGATION and INQUEST** On 2 August 2013 I commenced an investigation into the death of Peter Stanley (aged 17). The investigation concluded at the end of the inquest on 22nd July 2014. The conclusion of the inquest was that Peter took his own life by hanging but that there

	had been a number of missed opportunities to assist him by way of mental health assessment and care over the preceding weeks, most particularly towards the end of his life. However, it could not be said on the balance of probabilities that Peter would have survived if any or all of the opportunities had been taken.
	CIRCUMSTANCES OF THE DEATH
4	Peter Stanley, aged just 17, was found hanging in woodland on the outskirts of Sheffield on 2nd August 2013.
	There was a history of concern regarding Peter's mental health, his problems possibly originating from use of a so called 'legal high'. An assessment by an experienced community mental health nurse (CMHN) at the end of 2012 recognised that Peter could be developing a psychosis and he was offered a care-coordinator. Unfortunately Peter subsequently refused to engage. It was felt better that the service withdrew with an open invitation for Peter to re-engage when he was ready rather than 'harass' him and potentially spoil chances of later engagement.
	On the 10th April 2013 Peter presented himself to the local authority as 'homeless' because his parents could no longer cope with his behaviour. He was seen by a housing officer and social worker. Peter did not want to be 'looked after' (that is go into the care of the authority) and a bed was found at a suitable establishment ('Roundabout') to provide assessment and help with more immediate issues.
	On the 3rd May Peter saw his own GP complaining of an injury to his back from 'falling downstairs'. Although not disclosed at the time it is clear that Peter suffered this injury when attempting to hang himself on stairs at his mother's address. The significant nature of his injury suggests a violent episode and given his non-disclosure at the time it would be difficult to see this as anything other than a serious attempt on his life.
	On 14th July Peter committed a serious and violent episode of damage at Roundabout. He was barred from the premises and thus rendered homeless.
	Peter was arrested for the damage and seen in the detention area by a custody nurse, because he had been banging his head on the wall. He denied any history of mental health issues and said he was only banging his head to cause trouble. Because of his behaviour Peter was subject to constant supervision in the police cells. He also required full bodily restraint at one point.
	Peter appeared before the Magistrates from custody next day (15th July) and was made subject of a referral order to the Youth Justice Service. The Youth Justice team (YJT) were not made aware of the bizarre behaviour in custody and arrangements were simply made to see him a week later.
	Later that morning Peter (now homeless) attended at the local authority Housing Dept with his father, although [redacted] was not in the room for much of the interview. A social worker from Children's Services (SWCS) was also present. Housing had little to offer because of the circumstances in which Peter was removed from Roundabout and as there was no supported bed provision available he was declared 'intentionally homeless'. This left Peter to continue within the responsibility of Children's Services.
	Peter made a disclosure during this interview about his suicide attempt on the stairs but not whilst his father was present. In fact [redacted] never knew of the apparently serious attempt on the stairs whilst Peter was alive.
	There were continuing but unsuccessful efforts to find Peter more suitable accommodation than the Bed and Breakfast initially allocated. The SWCS apparently

	felt that the YJT would be the quickest route to a mental health assessment — but despite discussion about Peter the YJT were not given any information about the mental health history or needs and nothing was put in progress. Although the Children's Services record system clearly identified the CMHN's previous involvement, he was not contacted at any time before Peter's death On 31st July a YJT substance misuse worker, saw Peter for a drug screen (not in relation to mental health). Peter told her of many thoughts about suicide, of his attempt on the stairs now four months before and of hearing voices. He said that he felt very low and was so distressed that he wanted to run into oncoming traffic or slice his own leg off. He felt that he had very little support from anyone and feared that he might be schizophrenic. This was taken seriously and a meaningful risk of self-harm was recognised although not seen as immediate. An appointment to see the YJT mental health worker (who was on leave) was made for a few days hence. The SWCS was contacted but there was little more provided. Further action was left with the YJT pending the mental health assessment the following week. The YJT determined to support Peter pending the assessment -- but were not really equipped to do so. No contact was attempted with Peter's father, nor any attempt to seek a medical view of the situation by telephoning Peter's GP. The following day (1st August) Peter did not attend a planned course. The YJT telephoned him twice. The first time he was plainly under the influence of drugs/alcohol and said he was unwell. When called later he was incoherent. The YJT became very worried and called the SWCS. Nothing seems to have come from this save that arrangements were made for an out of hours team to telephone Peter each morning over the coming weekend. Peter's whereabouts were unknown as he was not at the B&B. In fact, Peter was actually with his father that same afternoon. He described Peter as withdrawn, abrupt and intolerant. He plainly didn't see his son as suicidal but then he had no knowledge of either the earlier attempt or of the disclosures to the substance misuse worker. They parted when he took Peter back to the B&B as he felt his behaviour was not acceptable for a planned visit to the family home. Peter's body was found some hours later. The circumstances were plainly of a deliberate self-hanging.
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) Peter's mental health problems may have stemmed from the use of a so called 'legal high'. I understand that some, but not all, mainstream insurers have been persuaded to adopt a policy of not offering cover to establishments that sell such substances. Can this be encouraged further? (2) When young people are discharged from, or have failed to engage with, Adult Mental Health Services there is no formal 'step-down' policy. The Sheffield Child Death

	Overview Panel advise me that this should include a referral to a Multi Agency Support Team or Community Youth team who can then establish a key worker and 'team around the child' approach. (3) On the basis of evidence given by [redacted] Assistant Director of Fieldwork Services, Sheffield City Council, it is clear that the custody nurse could have accessed the Children's Services records for Peter on 14 July, even during the night, by calling the Social Services 'out of hours' team. Every local authority has an out of hours system (which would cover adults as well). However I am told that this is not generally known amongst those providing custody medical services. (4) There is no specific requirement that health professionals completing assessments of young persons in custody suites include a thorough assessment of mental health. (5) A prisoner escort record (known commonly as a PER) would have been handed over from the police to the privatised court detention officers when Peter was produced before the magistrates. This contains details (inter alia) of risks, self harm issues, medical attention and warning markers. I understand that the Youth Offending Service believe that the PER should be routinely given to them it would inform assessments as to the immediate needs of the young person. This would only arise, of course, in the relatively few cases where the young person has spent a period in police cells. (6) Peter was classed as 'intentionally homeless' after his release from court on 15 July. [redacted] gave the court compelling evidence that this was wrong and that Peter should have been treated as a 'Child in Need'. Emphasis on the 'Child in Need' process when a young person was homeless would ensure proper assessment and sharing of information. Failures in sharing Peter's mental health history/needs were significant issues in this case. This emphasis is now standard practice in Sheffield but I understand it is not likely to be the case everywhere. (7) This case shows the need for a greater number of places in supported accommodation. (8) The Sheffield Child Death Overview Panel have also recommended that no young person should be deemed intentionally homeless. (9) It is evident that front line social services practitioners are not always aware of when and where to make mental health referrals. (10) It is understood that the number of Youth Offending Service staff who have access to, and training for, the Social Services records system is limited. (11) There is no system to ensure that where there has been previous psychiatric services involvement by a young person that such information will be used to inform assessment and the 'Child in Need' planning process. (12) There is no system to ensure that when a young person has presented with previous suicidal ideology that advice is taken from health professionals regarding the potential risks. (13) There is no system to ensure that 16 and 17 year olds placed in supported accommodation have needs based access to support services, including mental health and substance misuse, irrespective of whether they fall within s.20 of the Childrens Act.

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 **29 October 2014**. 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: • the family of Peter Stanley • [redacted] Exec Director for Children, Young People & Families, Sheffield City Council (copy to City Solicitors Dept) • Sheffield Health & Social Care Trust I have also sent it to the following who may find it useful or of interest: • Edward Timpson MP, Under Secretary of State (portfolio for children & families) • Youth Justice Team, Sheffield. • [redacted] Sheffield Child Death Overview Panel. • Chief Executive, Medacs Healthcare, Luton. • Clerk to the Justices, Sheffield. • Chief Executive, Roundabout. • [redacted], Hon. Secretary, Assoc. of Directors of Children's Services 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	**2 September 2014** ***Christopher P. Dorries***