DAVID W. G. RIDLEY
Senior Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Nick Walkley** **Chief Executive** **Haringey Council** **5th floor** **River Park House** **London** **N22 8HQ**
1	**CORONER** I am DAVID W. G. RIDLEY, Senior Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 16 January 2014 I commenced an investigation into the death of Mary Elizabeth Grace Stroman, aged 16. The investigation concluded at the end of a two day inquest on 16 October 2014. The conclusion of the inquest was that Mary took her own life whilst suffering from Complex Post Traumatic Stress Disorder. On 15 January 2014 she lay down on a railway line and was struck by a train between the stations of Westbury and Trowbridge in Wiltshire and died as result of multiple injuries.
4	**CIRCUMSTANCES OF THE DEATH** Back in 2010 Mary's family lived in Hackney and their GP was based in Islington. Problems began to appear towards the end of 2010 that resulted in Mary becoming a voluntary inpatient at the Priory North in December 2010. I found as a fact that Mary's Post Traumatic Stress Disorder that was subsequently diagnosed in 2011 was linked to mental trauma sustained as a result of episode(s) of sexual abuse. Expert opinion suggested that the index episode may have occurred 12 months prior to this possibly slightly earlier than that. There more likely than not were repeated incidents. The family moved to Haringey in the summer of 2011. It is quite clear from the evidence that I heard that there were concerns from a safeguarding perspective in relation to Mary's safety away from the family home in the community and in 2012 as early as February 2012 the Consultant Adolescent Child Psychiatrist, [redacted] part of the Wittington Healthcare Trust was of the view that Mary would benefit from long term therapeutic placement for up to 3 years which could meet her educational needs whilst maintaining her safety away from the area and in particular the London Borough of Islington. That placement finally began in June 2013. In Wiltshire she was seen by [redacted] the last consultation was 07 January 2014 where Mary was not exhibiting suicidal ideation or indicating a plan. For some reason which is unclear as contact with Mary throughout the day of her death indicated that there was nothing as regards Mary's behaviour that caused concern. She was in fact described as perky however at some point after 1920 on Wednesday 15 January 2014 she changed her clothes and walked some 800m to a nearby railway line where she proceeded to lie down on the track in front of an oncoming service from Portsmouth to Bristol. She died as a result of the multiple injuries she sustained in the collision.

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) Delay in the decision making process as regards funding the long term therapeutic placement

As early as February 2012 [redacted] as indicated in the previous section was supportive of the need for Mary to be placed on a therapeutic placement scheme away from the London Borough of Islington. That view was supported by [redacted] from Priory North and I am aware that they wrote to your local authority in November 2012 expressing their concerns due to the lack of progress. Due to the involvement of Islington who were supportive of the proposal from a healthcare perspective Mary's educational and Child social services responsibilities fell to your local authority following the family's move to Haringey during the summer of 2011. I heard evidence in the form of a report from [redacted] who stated that at a Haringey Complex Care Panel Meeting on the 09 May 2012 it was agreed that Mary's case for joint funded placement would be advanced. A letter from the panel subsequently stated that it accepted that Mary's needs to be given the opportunity to live outside the family home and that a range of options were going to be explored. I was informed by [redacted] that this decision was overturned by Children's Services on the basis it did not meet a threshold for accommodation under Section 20 and that it would not be in Mary's best interests. I am aware of the involvement of a local MP and the Stroman Family's lawyers who highlighted the local authority's duty here in terms of context and it was not until March 2013 that funding was authorised by your local authority. Again in [redacted] report he makes reference to a further report being commissioned by Haringey Children's Services in September 2012. The assessment was completed by [redacted] and it concluded "*My experience…. may be reflective of the paralysis within the care system around this patient but ultimately of the patient's own predicament*". Whilst in the terms of Mary's Inquest I did not find a direct causal link between the delay in funding Mary's placement I am concerned in relation to future cases that could impact on an individual's mental state and mental health. It is quite clear from the expert opinion evidence that I have read Mary's educational needs in particular were not being satisfied in either Simmons House or Priory North hence [redacted] nitial recommendation. The welfare of the child must be paramount and I would ask that you review the practises and procedures that were adopted here resulting in the decision to fund Mary's long term therapeutic placement with a view to ascertaining as to whether or not lessons could be learned with a view to improving the process and reducing the delay. I fully appreciate that Mary's case was exceptionally complex but I am concerned that the delay could affect other individuals if placed in a similar situation that may lead to self harming and even death.

(2) The temporary termination of the placement at Tumblewood - August/September 2013

As part of the evidence I was aware that Mary's placement was temporarily terminated as a result of an OFSTED inspection. Many pupils at Tumblewood including Mary arrive with a history of disrupted education. One of the reasons Mary was placed at Tumblewood was for this reason given her significant history of time as a voluntary inpatient in hospital and as an inpatient at another establishment both of which were felt by those involved not to address and meet her educational needs sufficiently. I am concerned as part of the process here that given that there was joint funding that the decision to terminate appears to be have been taken by your local authority without consultation with the other partner involved - Islington. I am additionally concerned as regards the general decision making process here assessing the safeguarding risk as compared to the benefit of allowing Mary to continue and return to her placement after the holiday period to an environment that provided stability rather than a situation

	whereby the alternative did not address her educational needs and was unsettling. At the Inquest I was satisfied that at the time of her death any issues that arose following her forced absence from Tumblewood were being addressed from the educational perspective which included involving Mary in that decision making process and that there was no direct causal link with her death. My concern is as regards the way your authority handles matters in the future which could potentially unsettle an individual's mental state possibly resulting in self- harm or even death. Again can I ask you to review the matter with a view to looking to identify any learning points and to communicate them back to me? In evidence I was unaware of any other pupil whose placement had been terminated as a result of the same report.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Mr Nick Walkley, Chief Executive of Haringey Council has 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 16 December 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 Kingley Napley LLP 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	Dated 21 October 2014 Signature_____ Senior Coroner for Wiltshire and Swindon