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.** The Rt Hon Jeremy Hunt, Minister for Health **2.** The Rt Hon Nicky Morgan, Minister for Education **3.** The Rt Hon Eric Pickles, Minister for Local Government
1	**CORONER** I am M Jennifer Leeming, Senior Coroner, for the Coroner Area of Manchester West
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 4th April 2014 I commenced an investigation into the death of Aleysha Martine Karla McLoughlin, Aged 16. The investigation concluded at the end of the inquest on 20th March 2015. The conclusion of the inquest was that Aleysha Martine Karla McLoughlin had committed Suicide. The medical cause of her death was 1a Hanging.
4	**CIRCUMSTANCES OF THE DEATH** On the 15th of July 2003 a Care Order relating to Aleysha McLoughlin was made at Manchester County Court upon the application of Bolton Council. Aleysha was then placed with a family member, where she remained settled until the 9th of September 2012 when she went to stay with her mother and refused to return. On the 8th of October Aleysha left her mother's address and although there was a short period thereafter when Aleysha returned to live with her family member the placement broke down. Accordingly on the 26th of November 2012 Aleysha was placed with a foster carer where she remained until her death in April 2014. As the foster carer lived in a different area Aleysha also changed schools, and at first she appeared to make a positive start at her new school. However from in or about March 2013 her schoolwork and behaviour began to deteriorate. Likewise Aleysha appeared to settle well with her foster carer. However on the 13th of March 2013 she left her foster carer's home and did not return until the 20th of March 2013. When asked where she had been Aleysha said that she had been with her mother.

In early June 2013 the head of Aleysha's year at school had a preventative meeting with her and her foster carer to address a perceived deterioration in Aleysha's behaviour. Aleysha did not engage at that meeting, and her behaviour was perceived to continue to be poor.

On or about the 8th of June 2013 Aleysha again left her foster carer's home and did not return until the 20th of June, on this occasion saying that she had been with her sister.

On the 25th of June 2013 whilst Aleysha's sister was visiting her at her foster carer's home Aleysha reported to her carer that her sister had taken an overdose. The following evening, the 27th of June, Aleysha herself took an overdose of aspirin and paracetamol. She was taken to the Royal Bolton Hospital where she initially refused treatment, and even after consenting she later removed the cannula administering intravenous medication and had to be persuaded to have it restored. During Aleysha's hospital admission clinicians from the Child and Adolescent Mental Health Services (CAMHS) assessed her and a further appointment was made for her to see a CAMHS clinical psychologist after her discharge from hospital. On the 5th of July 2013 Aleysha attended that appointment with her foster carer. Aleysha did not want any further involvement with CAMHS and as Aleysha's risk of further self harm was, for various reasons, believed to be reduced, it was decided that there was no ongoing role for CAMHS at that time, although an offer of re-referral was made should matters change.

When Aleysha returned to school after the summer holiday in September 2013 she was perceived as continuing to be uncooperative and difficult to engage.

On a date between in or about October 2013 and at or about Christmas of 2013 one of the Social Workers involved with Aleysha was informed by Aleysha's foster carer that Aleysha had inflicted some superficial cuts upon herself. The social worker believed that this was a historical event and did not ask Aleysha about it.

On the 7th of January 2014 Aleysha and her sister both took overdoses of aspirin and they were taken to the Royal Bolton Hospital. Clinicians wanted to admit Aleysha to the hospital for observation because she was believed to have taken a potentially life threatening overdose, but Aleysha refused to be admitted. She was seen by a Doctor in the Accident and Emergency Department of the Hospital, who decided that she had the capacity to refuse treatment and noted that she was discharged. Aleysha was subsequently seen by a Doctor specializing in mental health, who had concerns that Aleysha did not, in fact, have the capacity to refuse treatment. However medical staff would not then admit Aleysha to the hospital because a medical doctor had discharged her. Whilst discussions about this were continuing Aleysha left the hospital with her sister, who was also refusing treatment. Aleysha and her sister were returned to the hospital the following morning, and a mental health nurse who was a member of the Rapid Assessment Interface Discharge (RAID) team then assessed Aleysha. Aleysha continued to refuse to be admitted to hospital and was then assessed to have the capacity to make that decision. In the course of the assessment Aleysha told the mental health nurse that she had self- harmed

by cutting herself, although she had not done that recently. That information was not passed to other agencies. Particularly it was not contained in the information subsequently passed to CAMHS nor was it given to Social Services nor Aleysha's school. During the assessment Aleysha stated that she did not then want to end her life but that she had wanted to do so at the time when she had taken the overdose. At the conclusion of the assessment it was determined that whilst Aleysha was not at immediate risk of self harm she was at ongoing risk of impulsive self harm, and arrangements were made for her to have an appointment with CAMHS, despite Aleysha stating that she would not attend. Aleysha was also referred to the Safeguarding Children Team at the Royal Bolton Hospital.

On the 8th of January 2014 Aleysha was seen by her school nurse, who had been informed of her hospital attendance by the Safeguarding team. Aleysha declined further support from the nurse, who did not then contact Aleysha again.

On the 8th of February 2014 Aleysha and her sister were seen to be on the wrong side of the fencing of a road bridge where they were at risk of jumping or falling onto the carriageway below. Police Officers attended, and Aleysha walked off the bridge. She was then detained by the Police under the terms of the Mental Health Act and taken to the Royal Bolton Hospital, where she was seen by two Doctors specializing in psychiatry and an Approved Mental Health Professional who was a social worker, for the purpose of a Mental Health Act assessment. Aleysha did not fully engage during the assessment, and denied that she had intended to harm herself when she had been on the bridge. The assessment concluded that Aleysha was not at immediate risk of self-harm, but that she remained at ongoing risk of impulsive self-harm. Aleysha was then discharged from detention under the Mental Health Act. A further referral was made to the Safeguarding team and to CAMHS, although Aleysha again said that she would not attend at CAMHS, stating that she didn't need it. On the 11th of February 2014 a secretary working for the CAMHS team telephoned Aleysha and offered her an appointment with a mental health practitioner on the 17th of February, which Aleysha refused. On the 18th of February a social worker contacted a mental health nurse at CAMHS in order to share information regarding Aleysha particularly with regard to the events of the 8th of February described above. The ensuing discussion included an acknowledgement of the risks presented to Aleysha as a consequence of her impulsive behaviour when she was with her sister. Aleysha's refusal to engage with CAMHS was also discussed and the Social Worker planned that Aleysha's foster carer should be contacted and asked to encourage Aleysha to attend an appointment with CAMHS. On the 25th of February a multi agency meeting was held by social services to address Aleysha's self harming behaviour and her refusal to engage with CAMHS. CAMHS were not invited to this, nor to any other meeting. It was agreed that in view of Aleysha's refusal to engage with mental health services her foster carer should receive some training as to means of promoting Aleysha's engagement with those services. This training had not been put into place by the time of Aleysha's death on the 3rd of April 2014.

On the 6th of March 2014 Aleysha was excluded from school for five days due to her bad behaviour. A meeting took place with Aleysha and her foster carer and an individual programme of lessons was agreed, so as to support Aleysha

	during the period leading up to her forthcoming public examinations. On the 2nd of April 2014 a pupil at Aleysha's school told Aleysha's head of year that Aleysha had self-harmed by cutting her arms. Aleysha's social worker and her foster carer were informed and when they saw Aleysha an ambulance was summonsed and Aleysha was taken to the Royal Bolton Hospital with her foster carer following. When Aleysha was treated she was found to have twenty-nine recent lacerations on her left arm, together with scarring from older wounds. Neither Aleysha's foster carer nor Social Services had previously been aware that Aleysha was self-harming to this level. Whilst Aleysha's wound were being closed the treating nurse asked Aleysha if she wanted to see anyone from the RAID team, but Aleysha declined. Despite this the nurse contacted the RAID team and a mental health nurse assessed Aleysha. The assessment concluded that on this occasion Aleysha's self-harm was not an acute incident of attempted suicide but that Aleysha remained at ongoing risk of impulsive self-harm. The means of treating this risk was ongoing psychological therapy such as was offered by CAMHS and the nurse conducting the assessment encouraged Alysha to attend CAMHS despite her expressed reluctance to do so. At about 3pm on the 3rd of April 2014 Aleysha was found deceased by her foster carer at their home address [redacted]. She had hanged herself. Prior to her death she had been researching websites relating to suicide and hanging. She had also taken amphetamine, which could have induced depression.
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: Evidence was given at the Inquest that self harm in young people is becoming a public health crisis. Evidence revealed that 3 out of 10 young people have self harmed at some time during their lives. Accordingly the matters of concern revealed were as follows:- (1) That it should be considered that the system of training for those working with young people, including teachers, school nurses, foster carers, social workers, mental health workers and medical nurses and doctors should be reviewed so as to ensure that these professionals should be alert for signs of self harm and should take opportunities to discover themselves so that those harming themselves can be offered help and support. By way of example evidence was given at the Inquest that the annual health check offered to looked after children did not include a blood pressure check. If a blood pressure check was included this would provide an opportunity for signs of self harm to be revealed. (2) That it should be considered that additional information and encouragement could be offered to young people to inform those able to help for example teachers, nurses, health professionals etc. when a

	young person becomes aware that another young person is self harming. The shocking self harm to which Aleysha Martine Karla McLoughlin had subjected herself was only revealed when a school friend brought it to the attention of a teacher. There was no evidence that there was any system in place to encourage the passing of such information. (3) That it should be considered that systems such as those now being developed in Bolton should be further developed so as to ensure that multi agency discussions involving all relevant agencies are held urgently for those at risk of self harm and particularly for those who do not engage. Evidence was given that meetings concerning Aleysha Martine Karle McLoughlin did not include the Child and Adolescent Mental Health Services although evidence was given that their input would have been valuable. (4) That it should be considered that a particular pathway of help for young people who resist engagement should be developed. There was no evidence that any such formal pathway had been shared at the present time. (5) That a review of the capacity of the agencies involved in helping young people who are self harming to address those matters appropriately should be considered.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and 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 3rd June 2015. 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] (mother), [redacted] (father), [redacted] (sister), [redacted] (grandfather), [redacted] (great aunt), [redacted] (foster mother), [redacted] (solicitor for Greater Manchester West Mental Health), [redacted] (Litigation Department, Royal Bolton Hospital), [redacted] (Solicitor, Bolton Council) and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. 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** **8th April 2015**	**Signed**  **M Jennifer Leeming**