



	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Rt Hon Jeremy Hunt, Minister for Health, Richmond House, 79 Whitehall, London, SW1A</p>
1	<p>CORONER</p> <p>I am Penelope Schofield, Senior Coroner, for the area of West Sussex, sitting as Assistant Coroner for East Sussex.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 1st June 2016 I, together with a Jury, concluded the inquest into the death of Amy Rose El-Keria born 14th May 1998 (aged 14 yrs), who died on 13th November 2012. The Jury determined that Amy had died from the complications arising from Hypoxic Ischaemic Brain damage following the tying of a ligature around her neck. The Jury return a narrative questionnaire in which they found that Amy's death had been contributed to by Neglect and they also found that there were a number of causative failures which led to her death. A copy of the narrative questionnaire is attached.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Amy El Keria was aged 14 years old at the material time. She had a range of complex needs associated with a number of mental health diagnoses. Up until the time of her hospital admission she lived with her mother and sister in Hounslow. Following her exclusion from school in early 2012 her mental health deteriorated and she started to ligature. In August 2012 she was seen for an emergency outpatient assessment and a planned inpatient admission was sought. However there were no specialist Child and Adolescent high dependency beds available immediately and Amy had to be admitted to the Priory Hospital at Roehampton. The following day she transferred to the Ticehurst House Hospital which is part of the Priory Group. During her stay at Ticehurst Amy's mental health fluctuated and at times she had to be forcefully restrained and sedated.</p> <p>On 12th November 2012, having told staff earlier in the day that she wanted to kill herself, she tied a ligature, namely a football scarf, around her neck and suspended herself from a radiator in her room. She subsequently died from her injuries the following day.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>(1) The Jury in this Inquest found that the staffing levels, which were in line with the ONIC staffing ratio, were inadequate to give Amy sufficient one to one time in accordance with her care plan. It is understood that in December 2014 the Department of Health tasked NICE with developing guidance on staffing levels for inpatient CAMHS units but this appears to have</p>

been discontinued. There is currently no national guidance on staffing levels for inpatient CAHMS

- (2) There continues to be a shortage of acute mental health beds for young people close to where they live. This means that families have to travel long distances to visit their child and they are unable to provide the necessary day to day support to their child. Family support can play a very significant role in managing risk of suicide by avoiding and mitigating distress.

I consider that the issues raised in this case should be addressed so that future deaths do not occur in similar circumstances and that action should be taken to reduce the risk of deaths of other children.

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 by addressing these issues.

7 **YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of the date of this report, namely by 28th November 2016. 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:

1. [REDACTED]
2. The Priory Group
3. Hounslow LBC
4. [REDACTED]
5. [REDACTED]
6. West London Mental Health Trust

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.

DATE: 3rd October 2016

West Sussex sitting as Assistant Coroner, East Sussex

SIGNED: Penelope Schofield, Senior Coroner,