REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: College of Policing, Secretary of State for Education, Secretary of State for Health and Social Care
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 17th January 2019 I commenced an investigation into the death of Katie Croft .The investigation concluded on the 17th October 2019 and the conclusion was one of **Suicide**. The medical cause of death was **1a) Severe hypoxic-ischemic encephalopathy; 1b) Asphyxia from hanging**
4	CIRCUMSTANCES OF THE DEATH Katie Croft was a vulnerable child who was a victim of abuse which she reported. On 17th October 2018 Greater Manchester Police and Tameside Children's Services began an investigation. Katie was spoken to by both agencies having already given a detailed account to her school, which had reported the disclosure. The working together principles applied to the investigation which require that the voice of the child should be a focus for all agencies. Subsequently Katie via her mother indicated she did not want to support a prosecution. The case was closed by Greater Manchester Police without being countersigned by a supervisor or any further face to face discussion with Katie or assessment of the evidence. A multi-agency strategy meeting was held and concluded Katie was being safeguarded. A child and family assessment was subsequently completed by an agency social

worker from Children's Services without any further discussion with Katie. It was not shared with Katie or her family.

On 18th December 2018 Katie disclosed to her form teacher that she was considering self-harm or worse. A cause for concern form was completed but subsequently misplaced. Action was taken to notify her parents of Katie's disclosure and her mother was spoken to. Katie had previously self-harmed. No further action was taken in relation to this disclosure. On 8th January 2019 Katie sent her previous form teacher, who had left the school, a message via social media. She said she had no one else to talk to who knew what she was feeling and that she thought about the abuse every day and had cut herself the day before. The message was shared with the school safeguarding lead that evening and Katie was spoken to at school the following day. She denied sending the message.

She continued with lessons. School attempted to notify her family of the concern. After school she returned home. As a result of concerns raised by one of her friends school were contacted and contact was made with her family who tried to contact her and check on her wellbeing. Her friend went to check on her and found Katie suspended from a ligature at her home address.

She was resuscitated and taken to hospital. However she had sustained catastrophic brain damage and died at Royal Manchester Children's Hospital on 15th January 2019.

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. The inquest was told that GMP followed their own guidance which accorded with that of the College of Policing into the level of expertise of the officer allocated to investigate Katie's allegations. As a result of this the case was not dealt with by an experienced Public Protection or specialist sexual offences trained officer. It was allocated to a probationary police constable with approximately 6 months experience. The officer did not seize the phone which contained key social media contents until her third visit on the initial evening the offence was disclosed. The allocated officer was not experienced in joint working with social services or familiar with the concept of the voice of the child and what it would mean in such a case. At the time the decision was made by police to NFA matters there was no discussion about whether there could

be a victimless prosecution; it was not established if the initial account was recorded on body worn footage or the extent of the social media contact by the suspect and the nature of any offences that could be revealed by those messages. No attempt was made to have a further face to face conversation with Katie;

2. The Local Authority at the time were using a substantial number of agency social workers. As a result the Child and Family Assessment was not completed in accordance with best practice and not shared in accordance with expectations around best practice. The Local Authority has since made significant progress in moving away from a reliance on agency staff to fill gaps in social work cover. The inquest was told that agency social workers are still used extensively in other Local Authorities creating a risk that a similar situation could arise;

3. At the safeguarding strategy meeting an officer allocated to attend such meetings on behalf of GMP attended rather than an officer allocated to the case. As a result the quality of information sharing and understanding of the allegation was more limited. On the particular police division in question this practice has stopped. It was unclear how common the approach is on a wider basis;

4. It was accepted by witnesses for both the Local Authority and GMP that the voice of the child was not fully heard throughout their investigations. They via the safeguarding board commissioned an independent report whose findings and recommendations have been fully adopted by the safeguarding board. It was unclear what if any steps would be taken to disseminate the lessons pan GM or nationally;

5. A further concern identified was that there was no mechanism for the school to be formally be aware of information within the Child and Family Assessment. As a result there was no formal follow-up procedure set out in the best practice national guidance the school was working within. The inquest heard that Katie's school recognising this gap has built on the working together guidance to develop guidance that ensures there is a proactive approach to engaging with a child and their family post the writing of a Child and Family Assessment;

6. On the day Katie committed suicide she had attended a GCSE English class. The exam board required poetry syllabus was being studied that day. The lesson included a poem where the contextualisation of it included the use of suicide. The teacher delivering the lesson had no way of understanding the history of self-harm of Katie and her particular vulnerability when delivering a

	set text in accordance with the exam board requirements. It was unclear what if any guidance is given by the exam board to assist teachers minimising risk to pupils in this scenario.
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 14th January 2020. 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 namely 1) [redacted] on behalf of the family 2) Greater Manchester Police 3) Tameside Metropolitan Borough Council 4) Rayner Stephens High School, who may find it useful or of interest. 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	**Alison Mutch OBE** **HM Senior Coroner** **19.11.2019**