REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Chief Executive Officer, Youth Justice Board for England and Wales**
1	**CORONER** I am Guy Davies, Her Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.
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 14 September 2020 an investigation commenced into the death of 16-year-old Jake Adam Cahill. The investigation concluded at the end of the inquest on 13 January 2022. The conclusion of the inquest was as follows Medical cause of death: *1(a) Hanging* The four questions - who, when, where and how – were answered as follows: *Jake Adam CAHILL died on 14 September 2020 at* [redacted] *Cornwall by* [redacted] *being an impulsive act in a moment of crisis, that was wholly unexpected and could not have been anticipated.* Short form conclusion: *Suicide*
4	**CIRCUMSTANCES OF THE DEATH** Jake had been subject to police investigations for a minor criminal offence committed in March 2020. The police issued a conditional caution which was administered on 4 September 2020. Jake was clearly upset at being issued with a police caution and having conditions imposed. Subsequently the local youth

offender service (YOS) sent Jake's mother, [redacted], some documents for completion. This included a self-assessment form, being a document produced by the Youth Justice Board for England and Wales. The letter from the YOS instructed [redacted] to pass that self-assessment form to Jake for completion. [redacted] handed this form to Jake late in the evening of 13 September. The form was written in the first person and three questions were highlighted at Inquest, with a yes/no box for completion

- *I have thought about hurting myself*
- *I have tried to hurt myself*
- *I have thought about killing myself*

Jake ticked 'no' for each of these questions. The following day Jake took his own life.

In connection with the self-assessment form there was no evidence of any consideration being given to the need for sensitive questions raised in the form to be discussed with Jake by a professional before Jake completed the form.

Evidence was taken from police on the subject of the risk assessment forms used by police. These forms do include questions whether an individual intends to harm or kill themselves. This form is never sent to individuals but is always completed by the individual with an officer present, that officer being required to explain and if necessary, contextualise the questions.

The court heard that the guidance to the self-assessment form issued by the Youth Justice Board makes no express reference to the need for consideration to be given and documented as to whether the self-assessment form needs to be discussed with a vulnerable young person before completion of the form. The guidance examined at the Inquest was a document entitled '*AssetPlus guidance v2.0*'.

Jake had no history of any mental health conditions, or any history of self-harm or suicidal ideation. There was no evidence from friends and family of any warning sign as to Jake's state of mind.

Toxicological examination was negative, in other words no drugs or alcohol were found in samples of blood taken from Jake after death.

The police investigation had searched through Jake's browsing history. That enquiry revealed nothing of concern until the day of Jake's death 14 September 2020, by way of image caches captured on his browsing history as follows

- *0650 I'm so done with everything*
- *0713 Do you just deep how alone u truly are sometimes*
- *1027 I want to die by hanging myself. How do I make sure that it works? Will it hurt?*

	I made a finding of fact that the completion of that self-assessment form late on 13 September contributed to a moment of crisis for Jake the following day 14 September during which he took his life.
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) that there was no evidence of any consideration being given to the need for sensitive issues raised in the self-assessment form to be discussed with Jake by a professional before Jake completed the form. (2) that the guidance to the self-assessment form issued by the Youth Justice Board makes no express reference to the need for consideration to be given and documented as to whether the form should be discussed with a vulnerable young person before completion.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. • *I recommend that the Youth Justice Board reviews the guidance and procedures relating to the distribution and completion of the self-assessment form given to young persons.* I would be pleased to hear from you in relation to these concerns.
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 March 2022. 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] (Jake's mother) • [redacted] (Jake's father) • Youth Offender Service for Cornwall • 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	**01.02.2022** **Guy Davies, HM Assistant Coroner**