Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **The Rt Hon Steve Barclay, Secretary of State for Health and Social Care**
1	**CORONER** I am Penelope Schofield, Senior Coroner for the coroner area of West Sussex
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 10 May 2021 I commenced an investigation into the death of Robyn Lily Audrey SKILTON aged 14. The investigation concluded at the end of the inquest on 28 June 2022. The conclusion of the inquest was that: Robyn took her own life whilst struggling with her mental health. The mental health services failed Robyn as they did not recognise the deterioration of her mental health nor provide her with the care and treatment she required. Her death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** On 7th May 2021 Robyn Skilton was found in Southwater Park, having tied a ligature around her neck. Emergency services were called but death was confirmed at 1251 hrs. Robyn had a history of mental health problems which included self harming. Despite her deteriorating mental health, at the time of her death, she was still awaiting a formal assessment by a Child Psychiatrist.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) Robyn was failed by the Mental Health Services quite frankly due to the current lack of resourcing and provision in place to support young people struggling with their mental health. Due to the lack of availability of a Child Psychiatrist there are long waiting times for children to be assessed. Robyn was not seen by a Child Psychiatrist and/or Psychologist, despite there being a need for this to happen, thereby enabling her to be diagnosed and receive a treatment plan. Robyn's parents did everything they could during this period to support Robyn, including paying for a private counsellor, but sadly Robyn's mental health continued to deteriorate during this time, and she took her own life. Robyn initial acceptance into tier 3 Children and Mental Health Services (CAMHS) similarly did not happen in a timely manner.

	I do appreciate that the landscape that the local mental health Trust (Sussex Partnership Foundation Trust) was working under and the fact that Covid heightened the level of complexity across many services but there were many failings in the care provided to Robyn. It became very clear during the Inquest that there is significant under funding of the local mental health Trust who like many mental health Trusts have seen an explosion of referrals to their Children and Mental Health services (CAMHS). By way of an example:- Referrals to West Sussex CAMHS have increased by 95.6% from May 2019 (389) to May 2022 (761) West Sussex CAMHS caseload has increased by 85% from May 2019 (2239) to May 2022 (4147) West Sussex CAMHS Duty caseload has increased by 112% from May 2021 (492) to May 2022 (1494) Mental Health A&E presentations, in period April 2021 - March 2022, have increased by 40% on previous year (April 2020 - March 2021). Additionally, across Sussex CAMHS, as a whole, the referrals data shows:- • May 2022 was the highest number of referrals the service has ever received (1350). • Of those 1350 referrals, 80% (1,081) were accepted into the service. • In comparison, in May 2019, 579 were accepted (65% accepted) • So, an additional 502 young people have been accepted in May 2022 compared to May 2019 Despite the increase in numbers accessing CAMHS there has not been any relative increase in resources to meet this demand and therefore the current position is is unsustainable and it is putting many young people's lives at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 October 2nd, 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] I have also sent it to:- [redacted], Legal Director, Sussex Partnership NHS Foundation Trust [redacted], Principal Lawyer, Children & Advocany Team, West Sussex County Council [redacted] Solicitor for the family Russell-Cooke Solicitors who may find it useful or of interest.

	I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 7th August 2022**  **Penelope Schofield** **Senior Coroner** **West Sussex**