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 Chief Constable** **Sussex Police** **Church Lane** **Lewes** **BN72DZ** **Police and Crime Commissioner** **Sackville House** **Brooks Close** **Lewes** **East Sussex** **BN72FZ**
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 24th May 2020 I commenced an investigation into the death of Jade Hutchings aged 18. The investigation concluded at the end of the inquest on 28th September 2022. I concluded with a narrative conclusion of:- Jade, who was vulnerable, had been struggling with his mental health. He had been using alcohol and drugs to mask underlying issues and he had been finding it difficult to engage with services in order to address this. There were missed opportunities by a number of services to proactively engage with Jade to ensure that he was being encouraged to address his dependency on alcohol and drugs and notably the missed opportunity to carry out a child in need review when Jade was approaching 18 which did not occur due to his case being closed prematurely. Jade's death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** In 2019 Jade's behaviour started to deteriorate. He dropped out of St Pauls' College and started to get involved in criminal activity. He came to the attention of Children Services, the Mental Health Service and the Police (having been the victim of assaults, being involved in domestic disputes and having been arrested for aggravated burglary). Alcohol and substance misuse played a substantive part in his lifestyle. At 22:07 on 20 May 2020 Mrs Hutchings (Jade's mother) reported to the police that Jade (who was 18 at the time) had not returned home. She said that he had left the house at 17:00 under the influence of alcohol and drugs saying that he would be back soon. He didn't return so Mrs Hutchings contacted his friends but they had not heard from him. She was

	concerned for her son as this was out of character for him and he had previously been assaulted. The Police treated Jade as a missing person and tried to locate Jade. At 03:00 police located Jade at Hastings Town Centre. He was drunk. The Police did not detain him under Section 136 Mental Health Act as they did think it was necessary. They transported him back home to Haywards Heath. On arriving home he went to bed. When Jade woke up the following morning, he was argumentative with his mother. He eventually calmed down and apologised. Later that morning his mother and sister left the house to go to the shops. They arrived back home at about 14:00 and went upstairs where they found Jade hanging [redacted] Mrs Hutchings and some of her neighbours began CPR on Jade and an ambulance arrived along with several police officers who assisted with CPR. Jade was taken to Brighton Hospital where despite treatment he died on 23rd May 2020. The Cause of death is recorded as: - 1a Hypoxic Brain Injury 1b Asphyxia due to Hanging by Hanging 21/5/20
5	**CORONER'S CONCERNS** During 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: **1. <u>Inadequate Police training on Mental Health</u>** During the course of the Inquest officers involved in dealing with Jade (and in particular around the exercise of their Section 136 powers on 21/5/20) acknowledged that they had received very little mental health training. Some officers could not recall any additional training provided since their initial training when they first joined the force. The officers admitted that although they were aware of the Sussex Police mental health guide they had not read it in full. The expert police witness, [redacted], told the Inquest that in his view the online training provision that we were told was being rolled out in Sussex was not sufficient. None of the officers involved in this case had yet undertaken this online training. It was his opinion that officers should be provided with the nationally recognised two day training course written by the College of Policing, The course is available for all Police forces to be rolled out locally. This training had not been adopted by Sussex Police. There was also confusion amongst Officers (and a lack of clear understanding) around the provision and use of service the Haven at Millview could provide. **2. <u>REBOOT - Lack of provision to for older age group</u>** There was clear evidence that Jade was vulnerable and had become involved in violence and crime in 2019 (the year before his death). It was believed by some that Jade exploited by gangs running county line drug operations. A need for an early intervention was identified by his social worker and a referral to Reboot was made. The Inquest was told that at the time REBOOT was prioritising 12 – 14 years children and as Jade was nearing 18 they were unable to work with him. This was a missed opportunity for Jade to be involved in a form of early intervention before his life started unravelling and he became more heavily entrenched in the world of crime.

	It is understood that at the time of Jade's death the Police and Crime Commissioner was responsible for the REBOOT scheme but at the time of writing this report the scheme is now run by Sussex Police.
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 4th January 2023 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:- **a)** [redacted] **b)** [redacted] **c) Sussex Partnership Trust** **d)** [redacted] **(via legal representative)** **e) West Sussex County Council** 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	 **Penelope Schofield** **Senior Coroner** **West Sussex** **Dated: 28th October 2022**