

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none"> 1. Steve Barclay, Secretary of State for health and social care 2. Gillian Keegan, Secretary of State for Education 3. Chief Executive London Borough of Ealing 4. Chief Executive London Borough of Islington 5. West London Alliance
1	<p>CORONER</p> <p>I am Lydia Brown, Acting senior coroner, for the coroner area of West London</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 17 July 2017 I commenced an investigation into the death of Lance Scott Walker, age 18 . The investigation concluded at the end of the inquest on 21 November 2022. The conclusion of the inquest was</p> <p>Medical cause of death - 1a Shock and Haemorrhage 1b Stab Wounds to the back</p> <p>Lance Scott Walker was killed by The Assailant in the afternoon of 15 August 2016 in Gledwood Drive, Hayes. The immediate cause of death was shock and haemorrhage, due to stab wounds to the back. Numerous circumstances both probably and possibly led to this death.</p> <p>The jury Conclusion was as follows – (the questionnaire they responded to is attached for ease of reference):-</p> <p>The jury is satisfied by unanimous decision that, on the balance of probability, Lance Scott Walker was unlawfully killed.</p> <p>1. In response to the questionnaire: regarding the West London NHS Trust, the jury finds by unanimous decision errors, omissions, and failures that probably caused Lance Scott Walker's death, considering:</p> <ul style="list-style-type: none"> • Insufficient planning for the transfer of The Assailant's care from child and adolescent services to adult services; • Inadequate management of The Assailant's care following the transfer of his care from CAMHS to the Early Intervention in Psychosis team when he turned 18, including the administration of his depot medication and the absence of any contact with The Assailant, including by way of home visit; • The grave lack of any assessment in order to determine whether the assailant should be detained under the Mental Health Act of 1983 • Unacceptable assessment, if any, of the risks The Assailant posed to others,

including by way of violent offending, on and after 29 June 2016

- The insufficient communication on the part of the Trust with Urban Youth Flex and the London Borough of Ealing, including informing them of The Assailant's mental health, needs and risks and liaising with Urban Youth Flex and the London Borough of Ealing regarding the Assailant's mental health, needs, or Risks

2. In response to the questionnaire: regarding the **London Borough of Islington**, the jury finds by unanimous decision errors, omissions, and failures probably caused or contributed to Lance Scott Walker's death, considering:

- The unsatisfactory decision to commission Urban Youth Flex to provide unregulated accommodation to 23 Gledwood Gardens to Lance Scott Walker specifically regarding matters of financial due diligence and the absence of a contract, in particular detailing the expectations on the care provider – Urban Youth flex;
- Insufficient evidence to show suitable management of Lance Scott Walker during his placement in 23 Gledwood Gardens


3. In response to the questionnaire: regarding the **London Borough of Ealing**, the jury finds by unanimous decision errors, omissions, and failures that probably caused or contributed to Lance Scott Walker's death, considering:

- The inappropriate commissioning of Urban Youth Flex to provide unregulated accommodation at 23 Gledwood Gardens to The Assailant specifically regarding matters of financial due diligence and the absence of a contract, in particular detailing the expectations on the care provider – Urban Youth flex;
- The inappropriate placement of The Assailant in unregulated accommodation at 23 Gledwood Gardens managed by Urban Youth Flex;
- The grave omission of information regarding The Assailant by London Borough of Ealing with Urban Youth Flex when they placed The Assailant on 4 August 2016, including his forensic history, risk of offending, harming others and being bullied and details of his medication and medical regime;
- The grave lack of communication by London Borough of Ealing with the Trust and/or Urban Youth Flex after The Assailant's placement on 4 August 2016;
- The inadequate system in place whereby Merlins are shared with the allocated social worker;
- The unacceptable lack of escalation of The Assailant's specific case through the appropriate channels;
- The failing in proper internal communication between the various interested departments of the London Borough of Ealing with respect to The Assailant's case.

4. In response to the questionnaire: regarding **Urban Youth Flex (also known as Choices Homes)**, the jury finds by majority decision (8-2) errors, omissions, and failures that possibly caused or contributed to Lance Scott Walker's death, considering:

- The improper training, experience, staffing levels, and formal qualifications of the Urban Youth Flex staff working at 23 Gledwood Gardens;
- Urban Youth Flex's inadequate ongoing management of their tenant's suitability with one another, after (and only after) they were placed in 23 Gledwood Gardens;
- The failure to share information with the London Borough of Islington and London Borough of Ealing, including in particular the incidents on the 11th and 12th August 2016.

4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Lance Scott Walker was a “looked after” child who was entitled to be accommodated under the provisions of the Leaving Care Act. When his penultimate placement broke down, he was placed by London Borough of Islington in an unregulated residential home, 23 Gledwood Gardens run by Urban Youth Flex during 2016. He was 18 years of age. Several weeks later, another resident, referred to as “the assailant” also 18 years old was placed in the same accommodation as an emergency. 11 days after they were placed together, the assailant fatally stabbed Lance Scott Walker.</p>
A st	<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 could 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 Response requested from Secretary of State for Education and Secretary of State for Health and Social Care</p> <p>Lance was only exposed to his killer because he was obliged to live in the designated accommodation. Although the 2 relevant Councils were duty bound to house both individuals up until the age of 21 under the Leaving Care Act, there is currently no regulation for the over 18’s. Regulation is being introduced for 16-17 year olds in April 2023.</p> <p>Both Councils were in agreement that Regulation of this sector would be welcomed to support them in carrying out their statutory obligations. A set of minimum requirements to introduce clear guidance across the sector would benefit the residents, the providers and all stakeholders in this particularly challenging sector. Currently OFSTED does not have an obligation to be involved and this falls outside the CQC’s regulation as the provision is not for “care” but support. The provision is made from an entirely un-regulated sector, resulting in some organisations offering accommodation with inadequate training, staffing or knowledge to meet the complex needs of some of our most vulnerable individuals. Consideration should be given to introducing regulation for at least 18-21 year old individuals. This issue remains a concern for all those who work within it.</p> <p>2 Response requested from London Borough of Ealing, London Borough of Islington and the West London Alliance</p> <p>There is currently no standard referral form for service users aged 16-25 to be referred into supported housing. This means that best practise is not universally followed and it is more difficult for the stakeholders to have to deal with a number of different forms. Vital information can potentially be missed and issues not highlighted when a variety of forms are used for the same referral procedure. Consideration should be given to adopting a standard form across the West London Alliance, or even a national standard using “best practise” as the benchmark, for clarity and ease of reference.</p> <p>3 Response from London Borough of Ealing</p> <p>The Court was advised that the inquest had raised several points that will be further considered but that have not yet been addressed following this tragic death. In particular, system review of the “due diligence” in matching of individuals in the accommodation needs to be carried out and further lessons can</p>

	<p>be learnt in relation to the Borough's obligations in this regard. Strengthening the contractual elements between the Borough and Providers would ensure additional oversight of these relationships. Additional work in double checking and auditing placement forms needs further review to learn from the issues encountered in this case, and to improve the consistency and standard of referrals, with consideration on the introduction of mandatory fields for specific information to be included. The Borough undertook to enhance "New provider" scrutiny and approval in the light of the inquest findings. Confirmation of these positive steps and actions should be provided to allay the jury and Court's concerns arising from this inquiry.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 13 March 2023. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <p>The family of Lance Scott Walker ██████████, Director of Urban Flex Metropolitan Police Commissioner London Borough of Ealing London Borough of Islington West London Mental Health Trust</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest, and will therefore send a copy to OFSTED.</p> <p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<p>[DATE] 19/11/2023 [SIGNED BY CORONER]</p> 

**IN THE MATTER OF AN INQUEST TOUCHING UPON
THE DEATH OF LANCE SCOTT WALKER**

BEFORE HM SENIOR CORONER LYDIA BROWN

JURY QUESTIONNAIRE

Q1. West London NHS Trust

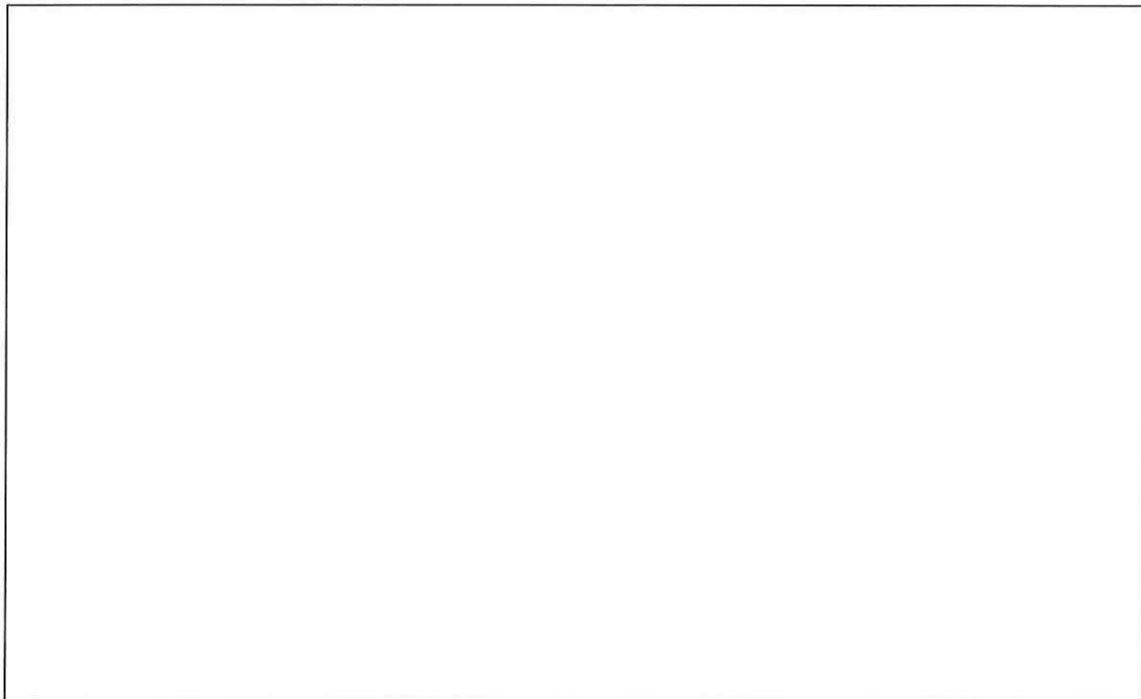
Question 1: West London NHS Trust	Answer
(a) Were there any errors, omissions, and/or failures by West London NHS Trust that probably caused or contributed to Lance Scott Walker's death? Answer "Yes" or "No".	Yes / No
(b) Were there any errors, omissions, and/or failures by West London NHS Trust that possibly caused or contributed to Lance Scott Walker's death? Answer "Yes" or "No".	Yes / No

In answering this question you may wish to consider the following issues:

- The planning for the transfer of The Assailant 's care from child and adolescent services to adult services;
- The management of The Assailant 's care following the transfer of his care from CAMHS to the Early Intervention in Psychosis team when he turned 18, including the administration of his depot medication and the absence of any contact with the Assailant, including by way of home visit;

- The lack of any assessment in order to determine whether the Assailant should be detained under the Mental Health Act 1983;
- The assessment, if any, of the risks The Assailant posed to others, including by way of violent offending, on and after 29 June 2016;
- The plans, if any, formulated in light of what was known or ought to have been known about the risks The Assailant posed to himself and others after 29 June 2016;
- The communication on the part of the Trust with Urban Youth Flex and/or the London Borough of Ealing, including informing them of The Assailant 's mental health, needs and risks and/or liaising with Urban Youth Flex and/or the London Borough of Ealing regarding the Assailant's mental health, needs or risks.

If you wish to provide an explanation you may do so on the on the pages that have been provided.

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Q2. London Borough of Islington

Question 2: London Borough of Islington	Answer
(a) Were there any errors, omissions, and/or failures by London Borough of Islington that probably caused or contributed to Lance Scott Walker's death? Answer "Yes" or "No".	Yes / No
(b) Were there any errors, omissions, and/or failures by London Borough of Islington that possibly caused or contributed to Lance Scott Walker's death? Answer "Yes" or "No".	Yes / No

In answering this question you may wish to consider the following issue:

- The decision to commission Urban Youth Flex to provide unregulated accommodation at 23 Gledwood Gardens to care leavers and/or Lance Scott Walker specifically, including regarding matters of due diligence and the absence of a contract.

If you wish to provide an explanation you may do so on the on the pages that have been provided.

Q3. London Borough of Ealing

Question 3: London Borough of Ealing	Answer
(a) Were there any errors, omissions, and/or failures by London Borough of Ealing that probably caused or contributed to Lance Scott Walker's death? Answer "Yes" or "No".	Yes / No
(b) Were there any errors, omissions, and/or failures by London Borough of Ealing that possibly caused or contributed to Lance Scott Walker's death? Answer "Yes" or "No".	Yes / No

In answering this question you may wish to consider the following issues:

- The commissioning of Urban Youth Flex to provide unregulated accommodation at 23 Gledwood Gardens to care leavers or The Assailant specifically including regarding matters of due diligence and the absence of a contract;
- The sharing of information regarding The Assailant by London Borough of Ealing with Urban Youth Flex when they placed The Assailant on 4 August 2016, including his forensic history, risk of offending, harming others and being bullied and details of his medication and medical regime;
- The sharing of information regarding The Assailant by London Borough of Ealing with London Borough of Islington to ensure that The Assailant and Lance Scott Walker were sufficiently compatible to be placed together with Urban Youth Flex;
- When and to what extent the London Borough of Ealing were made aware by Urban Youth Flex of an altercation(s) between The Assailant and Lance Walker, and the response if any to such information;
- The communication by London Borough of Ealing with the Trust and/or Urban Youth Flex after The Assailant's placement on 4 August 2016;
- The system in place whereby Merlins are shared with the allocated social worker.

If you wish to provide an explanation you may do so on the on the pages that have been provided.

Q4. Urban Youth Flex (also known as Choices Homes)

Question 4: Urban Youth Flex (also known as Choices Homes)	Answer
(a) Were there any errors, omissions, and/or failures by Urban Youth Flex (also known as Choices Homes) that probably caused or contributed to Lance Scott Walker's death? Answer "Yes" or "No".	Yes / No
(b) Were there any errors, omissions, and/or failures by Urban Youth Flex (also known as Choices Homes) that possibly caused or contributed to Lance Scott Walker's death? Answer "Yes" or "No".	Yes / No

In answering this question you may wish to consider the following issues:

- The extent to which Urban Youth Flex had staff working at 23 Gledwood Gardens who: (a) were appropriately trained; (b) were appropriately experienced; and (c) had an enhanced DBS check;
- The extent to which Urban Youth Flex had appropriate risk management systems in place;
- The extent to which Urban Youth Flex undertook an appropriate assessment of matching of proposed placements into their accommodation;
- The extent to which Urban Youth Flex appropriately shared information with the London Borough of Islington, London Borough of Ealing and the Trust, including in particular the incidents on the 11th and 12th August 2016;

If you wish to provide an explanation you may do so on the on the pages that have been provided.

