REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS Kent and Medway integrated care board**
1	**CORONER** I am Catherine Wood, assistant coroner, for the coroner area of North East Kent.
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 the 8th April 2022 I opened an inquest into the death of Stefan Kluibenschadl. At the inquest, which lasted two days and heard from a few of those involved in Stefan's short life, I concluded on 1st December 2022 with a narrative conclusion "He died as a consequence of his own actions, his intention being unknown"
4	**CIRCUMSTANCES OF THE DEATH** 1. Stefan suffered from autism and was at school at Laleham gap where he had been since April 2013. He had annual reviews of his placement at the school and was doing well and at the start of the winter 2020 term had managed to obtain a part time job and was considering career options of either the army or food industry. He had an extremely supportive family and parents who made significant efforts to ensure that he had access to the support he needed. 2. Both his parents and his school noted a decline in his mental health in December 2021 and he met with the school alongside his parents and his timetable was amended and steps to obtain additional support considered. On 14th January 2022 he told a member of staff at school that he had contacted the National Suicide Prevention helpline but later appeared to deny this. He apparently did not express any intent to harm himself but did express feelings of being low. 3. His parents, having tried to see what help was available locally, took steps to try to arrange private counselling and arranged for this to start after the February half term. The service the family approached did not consider Stefan was suitable for short term counselling and advice was given to approach his General Practitioner(GP). On 15th March 2022 Stefan's Mum spoke to his GP and asked for a letter to apply for funding from specific autism related counselling which his GP did but this was rejected and the letter received on 17th March 2022. At the consultation which occurred on the telephone between Stefan's mother and his

	GP there was no mention of suicidal ideation or self-harm. On Sunday 20th March Stefan was found hanging at home in his bedroom by his family and he was taken to hospital and subsequently transferred to Kings College hospital where sadly he died on 26th March 2022. 4. In the course of hearing the evidence it was clear that local mental health services were considered to be accessible via a Single Point of Access and that anyone could refer in this way and the healthcare provider would then screen any referral which was made and possibly provide treatment. However such a referral was not made for Stefan because it was not clear that this was available to Stefan's family who would have taken whatever steps they could have done to ensure appropriate support. His General Practitioner was aware of the Single Point of Access and that there were groups available but waits for specific services for those with autism in her experience were at least 3 months and instead she referred him to a different service at South London and the Maudsley which she considered may better suit his needs. The referral was rejected but the correspondence on this only came to light after Stefan's sad death.
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 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. During the course of the inquest reference was made to the National Institute for Clinical Excellence (NICE) guidance "Autistic Spectrum disorder in under 19s: support and management." Published on 28 August 2013 and in particular paragraph 1.1.4 which states that "*Local autism teams should ensure that every child or young person diagnosed with autism has a case manager or key worker to manage and coordinate treatment, care, support and transition to adult care in line with the NICE guideline on autism in children and young people (covering identification and diagnosis)*." Stefan did not have a case manager or key worker. 2. I am unable to say if the lack of a case manager or key worker caused or contributed more than minimally to Stefan's death but had one been available they may have been able to assist Stefan and his family to navigate the services available which in turn may have led to intervention which may have made a difference. I am prohibited from returning a conclusion which comments on issues where there is no clear causal link with the death however the Coroner's and Justice Act 2009 creates a duty on Coroners to report an issue which gives rise to

	a concern which may lead to future deaths. 3. I asked for further evidence on the provision of case managers/key workers in accordance with the NICE guidance after the inquest from North East London Foundation Trust and from Kent and Medway Integrated Care Board. It is clear from the evidence provided that such a service is only provided to those under 19 year olds who have both a learning disability and/or a diagnosis of autism and are at risk of admission to a mental health hospital or where there is a significant sudden deterioration in the community and the multi disciplinary team has not been responsive. The lowest level of service outlined in reply to the court indicated that referrals could be made to a key worker to sign post families not that they would have a key worker allocated to them. This sets the bar at a level which means a large number of young people with a learning disability and/or autism would not have a key worker nor would they be expected to have one . 4. In the evidence provided it was outlined that *"Keyworkers will make sure that these children, young people and families get the right support at the right time. They will make sure that local systems are responsive to fully meeting the young people's needs in a joined-up way and that whenever it is possible to provide care and treatment in the community with the right support this becomes the norm."* If every autistic child or young person had a key worker this would enable them or their family the opportunity to liaise with their key worker rather than having to try to navigate services themselves. This, in turn, may prevent others from encountering the issues faced by Stefan's family and ultimately prevent future deaths.
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 17th April 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 namely the family, his GP and North East London NHS Foundation Trust. 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	**19 February 2023**  **Catherine Wood** **Assistant Coroner** **North East Kent**