	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Department of Health and Social Care 2. NHS England
1	**CORONER** I am Assistant Coroner John Taylor for South London Coroner's Court
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: Samuel Thomas Howes** On 17th September 2020, the Senior Coroner commenced an investigation into the death of Samuel Thomas Howes. The investigation concluded at the end of the inquest on 30th March 2023. **Medical Cause of Death** 1a Multiple Traumatic Injuries **How, when and where and, for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death.** Shortly after 9am on 2 September 2020, Samuel Thomas Howes suffered fatal injuries when he jumped in front of a train [redacted] He did so in the following circumstances: a) Samuel suffered from ongoing mental health issues including anxiety and depression. b) Samuel's mental health led to his use of drugs and dependency which exacerbated his poor mental health. c) Samuel was a looked-after child, living in a placement residence d) That he was free to, and did, leave that residence

e) That early on 2 September 2020, he was recorded by police as being a 'missing person'
f) That police did not succeed in finding him before he jumped in front of the train

Below are also matters admitted by interested persons:

a) Following Samuel's arrest on 30 August 2023, neither of the safeguarding forms (specifically, a CYP and a DASH form) was completed by officers of the British Transport Police (BTP)
b) The Metropolitan Police Service (MPS) did not request Samuel be assessed by healthcare professionals (in particular a Custody Nurse Practitioner or a member of the Liaison and Diversion Team) while in custody on 30-31 August 2020.
c) The MPS did not progress the investigation to locate Samuel after 3:15pm on 2 September 2020 and before actions were set at 08:04am on 2 September 2020.

CIRCUMSTANCES OF THE DEATH

A jury found:

Suicide

Samuel's mental health and his use of drugs and/or alcohol probably contributed to his death.

We believe that the following matters also possibly made more than minimal, trivial or negligible contributions to his death

a) The inadequate response of mental health and social care services in relation to Samuel's dependency on alcohol and the possibility of a rehabilitative placement.

There were inadequate provisions for Samuel's complex needs. In particular, it was noted that no alternative treatments were proactively pursued. The agencies identified Covid as an obstacle to justify their inadequate responses.

b) The failure to inadequately share risk information by Social Services and/or Mental Health Services with each other, and with the police.

A number of factors were noted in this regard:

- Missing risk assessments were not completed consistently
- The Grab Pack was not completed
- iii) Samuel's vulnerabilities and suicide notes were not adequately communicated to the police by Social Services

c) The sharing of risk information by the MPS and/or BTP with partner agencies.

A number of factors were noted in this regard:

- There was a failure to share risk information by the MPS with BTP, as well as with partner agencies.
- In particular, there was a failure to complete and update the CYP Forms, or Merlin, as a result of each agency using their own platform.
- In addition, the BTP did not access the PNC to identify Samuel's Warning Markers

d) Steps taken by the MPS to seek an assessment of Samuel's mental health by a Liaison and Diversion Practitioner whilst he was in custody on 30 and 31 August 2020

The following was noted in this regard:

- Actions noted on THRIVE regarding the provision of a mental health assessment for Samuel were not followed up on multiple occasions.

e) The inadequate approach of staff and the safeguarding processes within Croydon Custody Suite

A number of factors were noted in this regard:

- Samuel's actions were regarded as 'attention-seeking'.
- The DASH and CYP Forms were not completed.
- The limited collaboration between the MPS and BTP led to a lack of recognition of Samuel's mental health needs, resulting in inadequate care.

f) Failures by multiple agencies and the inadequate response to the 'missing persons' investigation conducted by the MPS

A number of factors were noted in this regard:

- Failure to share information by different agencies
- Failure by multiple agencies to contact Samuel's family when he went missing.

g) Samuel's interactions with his girlfriends

The following was noted in this regard:

- Samuel's relationships were described as 'chaotic' and this impacted on his mental health and his behaviour
- In particular, the texts from his girlfriends telling him to 'kill himself' as well as the threats by another girlfriend to end her life, had a significant impact on Samuel's behaviour.

5	**CORONER'S CONCERNS** During the course of the investigation, 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** (some of which overlap) are as follows: (1) Samuel's case should be a stimulus for some level of Child & Adolescent Mental Health Service reflection on how different Child and Adolescent Mental Health Service teams are organised and work together. (2) The delayed response of the Adult Complex Additions Service to referral and issues related to provision of care to adolescents presenting with mental health vulnerabilities and substance use difficulties. (3) The lack of a complex service providing, to adolescents, treatment for both substance misuse and mental health issues models, in terms of willingness to engage, being problematic for some young people. (4) The inadequate response of mental health and social care services in relation to Samuel's dependency on alcohol and the provision of a rehabilitative placement. (5) Samuel's mental health and his use of drugs and/or alcohol probably contributed to his death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, the Department of Health and Social care and NHS England, 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 19 June 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:

	• The family of Samuel Thomas Howes • London Borough of Croydon • South London and Maudsley NHS Foundation Trust • The Childrens Commissioner (the deceased being a minor at the date of death). 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	**[DATE]** 24th April 2023 **[SIGNED BY CORONER]**