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:** 1) The Chief Executive of Reading Borough Council 2) Chief Executive of Berkshire Healthcare NHS Foundation Trust
1	**CORONER** I am HEIDI J CONNOR, Senior Coroner for Berkshire for the coroner area of Berkshire
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** I conducted an inquest into the death of Lucy Anne Walles, which concluded on 16th June 2023. I recorded a conclusion of suicide. I concluded that her cause of death was : 1a Traumatic brain injury 2 Polytrauma
4	**CIRCUMSTANCES OF THE DEATH** Lucy was born on 17th November 1997. She was 24 at the time of her death. Her death in hospital on 23 February 2022 happened after she jumped f [redacted] on 16 February 2022. The key facts for the purposes of this report are as follows: • Lucy had mild learning disabilities but had capacity to make her own decisions and go out alone. She needed support with everyday tasks and remembering to do things. • Lucy lived in supported accommodation in Reading, funded by Wokingham Borough Council. A support worker was provided by a care provider (Dimensions). **Mental Health Support:** • Lucy had some interactions with mental health services over the years, and we focused on her most recent contacts. Lucy was under the care of the Crisis Home Resolution and Treatment Team (CRHTT, hereafter referred to as 'the crisis team') between 11th January and 2nd February 2022, after an overdose. She was discharged from mental health services with a recommendation to refer herself to a group called SUN (Service Users Network). She had been told at that point that she did not meet the criteria for the learning disabilities team and was advised to speak to her GP herself from that point. • She saw a mental health practitioner based at her GP surgery on 15th February, indicating that she had thoughts of jumping from a particular bridge in Reading. The crisis team was contacted. Their advice was that, Lucy had

	been discharged recently from the service, and that she did not meet the criteria for being taken on by them. The recommendation for Lucy to refer herself to the SUN group remained. They did not speak to Lucy at that point. They did not offer her support from other mental health teams. **Safeguarding referrals:** • There was at least one earlier safeguarding referral, but we focused on those in the last 12 months of Lucy's life. • A safeguarding referral was sent to Reading Borough Council in May 2021 following an incident where Lucy took too many sleeping tablets. This report referenced Lucy's past history of deliberate self-harm. The evidence suggests that this was not reviewed by Reading Borough Council for almost 3 months – in August 2021 – when it was deemed to be an inappropriate referral on the basis that it did not describe abuse or neglect. • Between 10th and 20th January 2022, 3 separate safeguarding concerns were raised with Reading Borough Council. These are referred to below. • On the 10th January 2022, a safeguarding referral was made regarding an overdose of Nurofen tablets. • On the 18th January, there was an update on the above referral, but this related to additional incidents, including ingestion of bleach. When this was followed up by telephone (with the person who had made the referral) RBC's record of this conversation includes the following: *Lucy has allegedly done a few more self-harm attempts…she is making several threats of suicide ([redacted] . Today she tried to [redacted] …her mental health seems to be deteriorating…Dimensions believe she needs more support than what they can provide as they are not mental health skilled professionals.* • Subsequent to the referrals on 10th and 18th January, a social worker recorded that she did not think that Section 42 [of the Care Act] criteria were met. She also concluded that there was "*robust support from agencies involved and appropriate measures have been taken to address risks posed by her threats of self-harm. No serious harm has occurred to Miss Walles"*. • On 20th January, South Central Ambulance Service Centre made a safeguarding referral. This referral relates to a previous overdose, and mental health deterioration. The report said that Lucy had told them she did not want to be here anymore. • During all of these safeguarding referrals, Lucy was not contacted at all. It appears that the only information taken into account in reaching conclusions was the initial safeguarding report itself and information on Reading Borough Council's computer system (Mosaic). These would have included earlier safeguarding reports. • After the third safeguarding concern was raised by the ambulance service, no review or action took place before the tragic events of 16th February 2022.
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) The concerns arising out of this investigation and inquest relate to the following key areas,

	a) Safeguarding b) Mental health provision c) Inter-agency communication – particularly where there is some doubt over who should provide additional support needed by a person. We heard in evidence that in the months after Lucy's death, a Safeguarding Adults Board considered the case, but did not consider that a Safeguarding Adults Review ('SAR') should be undertaken. Evidence from Wokingham Borough Council was that they were not at that time aware of the number of safeguarding referrals that had been made. A decision was made (some six days before the inquest) that a SAR will now be conducted. The evidence of the Assistant Director of Adult Social Care was that this is likely to be completed within 1-3 months after the inquest. I have set out the issues / concerns that I have for each of the two recipients of this report, below. **Reading Borough Council** 1) Time scales for review and triage of safeguarding referrals. 2) Requirements to speak to the individual about whom safeguarding concerns have been raised. 3) Training around Section 42 and when a report meets the threshold for neglect or abuse. This training should also consider what options are available if a concern does not meet the threshold for a Section 42 enquiry. 4) Systems for making other involved agencies aware of safeguarding referrals and concerns. 5) In relation to each of the above points, whether RBC should reflect the above changes in formal (written) policy, as well as delivering training. 6) Improving interaction amongst agencies involved, and consideration of the threshold for arranging joint meetings to discuss service users, whether they meet Section 42 thresholds or not. The evidence we heard is that this is now being actively encouraged. Should there be written guidance about this somewhat subjective issue ? 7) Whether they consider that the resourcing of this service is adequate and safe. 8) Systems for auditing, and what will happen if the auditing reveals ongoing issues. **Berkshire Health Care** 1) How do the changes/proposed changes to systems (including the 'One Team' approach) make a difference? Specifically: a) Is the trust able to say with any confidence that a patient like Lucy would not be discharged from the crisis team without additional support, as she was on 2nd February? b) Is the trust able to say with any confidence that a patient like Lucy would be offered some support, whether by the crisis team or otherwise, in the situation that arose on the 15th February? 2) Do they consider that resourcing of these services is adequate and safe?
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**

	A response to a regulation 28 report is usually required within 56 days of the date of the report. Given the forth coming SAR, and in order to maximise the benefit of both of these investigations, I indicated at the inquest that I would allow a 4 month time period for this response, namely by 22/10/2023. 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 Lucy's family. I have also sent this report to the following recipients, who have an interest in this matter: 1. Legal representative for Wokingham Borough Council. 2. Legal representative for Dimensions. 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. 22/06/2023
9	**Dated: 22/06/2023**  **HEIDI J CONNOR** **Senior Coroner for Berkshire for Berkshire**