MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
Coroner's Court, 124 Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Royal College of Paediatrics & Child Health, NHS England** [redacted] **2. [redacted] President, Royal College of Psychiatrists, London Office, 21 Prescot Street, London, E1 8BB** [redacted] **3. Rt Hon Steve Barclay MP, Secretary of State for Health & Social Care** [redacted]
E	**CORONER** I am Nadia Persaud area coroner for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 3 August 2022 I commenced an investigation into the death of Allison Vivian Jacome Aules. Allison was 12 years old when she passed away on the 19th July 2022. The investigation concluded at the end of the inquest on the 17th August 2023. The conclusion was that Allison died as a result of suicide, contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH**

	Allison Aules was referred to the mental health team in May 2021 with concerns around evidence of self-harm, low mood, anxiety and enuresis. Her case was inappropriately screened as routine and the referral was triaged 8 weeks later. Allison was not communicated with at this time, but her mother shared a full account of concerns with the triage psychologist. Additional concerns were raised during triage and the matter was taken to a multi-disciplinary team. The team decided that Allison should be assessed face to face. They determined the case to be low risk and placed it in the green zone. The concerns shared with the service should have resulted in a more urgent face to face assessment. The assessment of Allison took place 9 months later. This was not a face-to-face assessment, as directed by the multi-disciplinary team. There was a telephone discussion, initially with Allison's mother alone. Allison later spoke to the assessor but there was no full assessment of her mental state. There was no full exploration of the concerns raised in the referral and in the triage discussion. There was no evidence of the assessor determining the cause of Allison's worrying presentation. There was no carefully documented assessment of risk. There was no carefully devised risk management plan. A decision was made to discharge Allison from the mental health team, with no multi-disciplinary review or liaison with the referrer. Allison continued to receive counselling provided at her school, but this concluded at the end of term, on the 15 July 2022. On the 18 July 2022 Allison was found suspended in her bedroom. The failure to provide basic mental health care to Allison contributed to her 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. – The Inquest identified multiple failings in the care provided to Allison. The failings occurred within a children and adolescent mental health service which was significantly under resourced. The Inquest heard evidence that the under resourcing of CAMHS services is not confined to this local Trust but is a matter of National concern. The under resourcing of CAMHS services contributed to delays in Allison being assessed by the mental health team. The delay between triage to assessment was 9 months. The Inquest heard evidence that this delay is not unusual within CAMHS teams across the country. There was very little evidence of any consultant psychiatrist leadership within the CAMHS team. The Inquest heard of the difficulties in recruiting suitably qualified psychiatrists to CAMHS teams. The Inquest heard that funding for CAMHS teams within the allocation of funding for general mental health is poor. The Inquest heard that the number of children presenting to CAMHS teams is increasing significantly. The number of referrals of children to the local CAMHS team in the early 2010s was between 10 – 12 per week. The current number of referrals is in the region of 140 patients per week. There is a concern that ongoing under resourcing of CAMHS services (whilst demand continues to increase), will result in future similar deaths.
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 **25 October 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, to the family of Allison Aules and to the other Interested Persons involved in the Inquest. The report will also be sent to the Care Quality Commission, to the Child Death Overview Panel and to the local Director of Public Health 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 other 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.
9	**30 August 2023**