ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Department of Health and Social Care** **2. Department of Education**
1	**CORONER** I am Abigail Combes, assistant coroner, for the coroner area of South Yorkshire (West District)
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 21 July 2022 I commenced an investigation into the death of Alex Dews born on 7 November 2008. The investigation concluded at the end of the inquest on 7 September 2023. The conclusion of the inquest was:- On 14 July 2022 Alex Dews went to a bridge in Dearne Valley Country Park, Barnsley. He fell from the bridge to the shallow river below. It is not clear the mechanism of that fall as this was unwitnessed. It is also not clear whether Alex intended to end his life in the fall from the bridge. Alex was found by someone passing and the ambulance service attended and transported him to Sheffield Children's Hospital where he died on 18 July 2022. The medical cause of death was: 1a: Hypoxic Ischaemic Brain Injury 1b: Traumatic Brain Injury and Drowning
4	**CIRCUMSTANCES OF THE DEATH** Alex Dews was born on 7 November 2008. Alex was born female however in his teenage years he identified as male and asked for his mum to notify his school of his change of name. Alex was loved and well supported by his family throughout his life and his family were a big source of security and support and he could readily talk to them about what he was experiencing. Alex's school acknowledged Alex's decision about his identity and immediately ensured this was communicated with the relevant people within the school and placed him on the vulnerable register in line with established practice. Due to Alex's protected characteristic this meant that he would be discussed on a

weekly basis. Although there are no minutes of this meeting it is clear on the basis of the evidence that I have heard that he was discussed on a weekly basis although there were not always actions which were needed.

There was an incident on 4 November 2021 [redacted]. There is evidence that this was on school premises and he was seeking advice from his grandmother about what to do. His grandmother has indicated in evidence that she was contacted by the school who outlined the injury. This is not documented by the school however I am satisfied on the balance of probabilities that this incident happened and the communication is as Alex's grandmother has described.

There was then a further incident which was disclosed to Ad astra about self harm and that resulted in Alex being placed on the waiting list for iSpace (the schools counselling service) at his mother's request. This was documented on the vulnerable register on 22 November 2021.

On 15 March 2022 Alex wrote a letter in school which he gave to one of his teachers indicating he wished to end his life. This resulted in a risk assessment by the safeguarding lead who subsequently pushed Alex up the iSpace waiting list and advised his mother to take him to A&E if she was concerned.

On 23 March 2022 there was a further disclosure that Alex wanted to kill himself to staff at the school.

On 25 March 2022 Alex commenced the counselling services from iSpace.

During the second session of counselling Alex disclosed that he had taken an overdose [redacted] This was conveyed from the Counsellor to the school safeguarding team and family were made aware of the disclosure.

In May 2022 Alex had received his full sessions of counselling and was discharged from those counselling functions. The discharge email made reference to Alex potentially benefitting from these services in future but there was no time frame on this.

It would appear that from the records and the evidence which I have heard there was an escalation in Alex's behaviour towards staff and involvement at school. This was out of character for Alex and his family would invite me to consider that this was evidence of Alex's deteriorating mental health.

That said, Alex's last report at school indicated that he was putting in significant amounts of evidence at school and doing well.

After his discharge from counselling services in May 2022 there is no evidence of episodes of self harm or suicidal thought in school documentation however he was still discussed each week on the vulnerability register meeting.

Staff were concerned that Alex would struggle in the following year of school and therefore determined that it was appropriate at that point to make a referral into CAMHS services for Alex. This had previously been discounted on the basis that the waiting list was so long and that if Alex was in receipt of iSpace support he would not be eligible for CAMHS services.

The CAMHS referral was made on the 27 June 2022. I have not heard any evidence

which suggests this was as a result of specific concerns about Alex's well being.

On 14 July 2022 Alex went to a bridge at Dearne Valley Country Park, Barnsley he climbed onto a bridge and fell from the top into shallow water. He was found and recovered to Sheffield Children's Hospital where he died on 18 July 2022.

<u>During the inquest the following Findings were made:-</u>

a) Alex was a vulnerable young person with mental health condition who required some additional support

b) Alex's school were notified of Alex's vulnerability and immediately placed him on the vulnerability register to ensure that he was monitored throughout his time at school. This meant that he was discussed weekly in varying depths.

c) Alex self harmed whilst at school on 4 November 2021 which did not generate any action by the school in terms of referrals or risk assessment

d) Alex disclosed to another worker on 11 November 2021 that he had self harmed and this was reviewed and assessed by the safeguarding lead who placed Alex on the waiting list for iSpace counselling services to support him.

e) On 15 March 2022 Alex produced a note at school stating that he wanted to kill himself and provided this to a teacher. The result of this was that Alex was given a referral to iSpace services more quickly having been risk assessed by the safeguarding team.

f) Alex's family were made aware of this incident on the 15th and advised to take Alex to A&E in the event that there were other concerns.

g) On 23 March 2022 Alex disclosed to a member of staff that he wanted to kill himself again which was two days before he first received counselling support from iSpace.

h) On 25 March 2022 Alex commenced iSpace counselling and during his second session disclosed that he had taken an overdose [redacted]. This was reported to safeguarding at the school who ensured that his family were made aware of that disclosure.

i) Alex was discharged from services in late May 2022 with a recommendation that there would be benefit from sessions in the future. There was no clarity around how far into the future this would need to be.

j) Following Alex's discharge from services there were no further clear episodes of self harm or suicide which the school have documented prior to his death.

k) In May 2022 Alex's mother disclosed to the school that Alex was stealing scissors from school to self-harm.

l) It is clear that a large issue for the School was that they would like to have made a referral to CAMHS however their experience indicated that if this happened they would discharge Alex from their service because he was receiving services elsewhere. This effectively puts the school in the position of making the referral and leaving Alex with no service provision for the immediate risk, or providing a service which would preclude mental health services being provided in the

	longer term. m) I am satisfied on the balance of probabilities that there was no real and immediate concerns for Alex's mental health which the school had and could reasonably have done anything about from May to the point at which Alex died. n) That said, there are concerns about the way in which the school have documented matters and the way in which the school assess and check the assessments of pupils when there are concerns. o) I am also concerned that the information shared with iSpace and others is hugely subjective and not standardised in any way shape or form. I am concerned that the school is not provided information from iSpace in the form of a final report not about what the child has disclosed but in respect of any advice and guidance which is given or any other follow up actions that are required (such as future sessions being planned). p) I am satisfied that the referral to CAMHS was a pre-emptive measure in anticipation of Alex's following year at school. Had staff felt that Alex was at immediate risk when they made the referral on 27 June 2022 I am satisfied that they were less likely to make a referral to CAMHS and instead would have advised A&E or an escalation to iSpace. This is on the basis of the evidence which I have heard regarding the difficulties staff have had over making referrals to CAMHS.
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. Alex was not referred by school to NHS mental health services as a result of their experience that if Alex was in receipt of any other support he would not be accepted onto the waiting list (which would be in excess of 10 months to be seen). 2. The school chose to provide Alex with school procured psychology support however the process of allocation of provision was not clear. 3. The school did not have a clear communication process with the provider of support to either refer the student into services or to receive outputs from those services once the student completed their sessions
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. I would ask that your responses specifically consider the following:- **Department of Health and Social Care** Part of the challenge for the school was the decision about whether to obtain quick support for Alex through their counselling provision or whether to place Alex on a long waiting list for Children and Adolescent Mental Health services. They were not able to offer both as he would be removed from NHS services if he was receiving other service. The provision of services for children and young people experiencing mental health difficulties carries long waiting lists and mitigation cannot be implemented where they

	will be removed from the waiting list for having that in place. **<u>Department of Education</u>** The provision of support services in school is not clear and consistent. The school in Alex's case had to put in place their own provision as the Local procurement was delayed. In any event there is a lack of clarity around what should be in place in school in terms of counselling for those who may be transgender or questioning their identity or whether this is solely a role for Children and Adolescent Mental Health services. **<u>Outwood Academy</u>** The school did not have clear objective referral documentation in place for someone in Alex's position which would assist with consistency of decision making. The school also did not have clear guidance from the psychology provider about what concerns may have been raised during counselling or what steps the school could take to support Alex following his sessions. There was reference to re referral but again there was no detail around this and the school did not enquire.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 5 December 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: Alex's family and Outwood Academy Trust. 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	 **10/10/2023** **Abigail Combes**