# Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1 The Rt Hon Victoria ATKINS MP**<br>**2 [redacted], Chief Executive NHS England** |
| **1** | **CORONER**<br><br>I am Darren Stewart OBE, Area Coroner, for the coroner area of Suffolk. |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 12th August 2022 I commenced an investigation into the death of Madeleine Eve SAVORY. The investigation concluded at the end of the inquest on 7th August 2023. The inquest was heard without a Jury.<br><br>Madeleine died of:<br>1a. Hypoxic Ischaemic Encephalopathy<br>1b. Asphyxiation by Hanging<br><br>I returned the following narrative conclusion:<br><br>Madeleine Savory died as a result of Suicide whilst suffering from the effects of a mental health illness. Madeleine's death probably was more than minimally contributed to by the failure of East Suffolk and North Essex NHS Foundation Trust to implement relevant policies which specifically dealt with the management of children such as Madeleine. This led to;<br><br>a. Staff on Bergholt Ward not having the necessary understanding of Madeleine's risk and how to manage this.<br>b. Ongoing failures to conduct risk assessments for Madeleine. During the time of Madeleine's admission there were only three risk assessments conducted and these were conducted on an ad hoc basis.<br>c. Ongoing failure to ensure relevant information about Madeleine's level of risk and the management of this was communicated to all staff involved in Madeleine's care. This included the recognition and communication of the fact that the bathroom posed a particular risk for Madeleine.<br><br>There was a failure on the part of Northgate High School to effectively implement the safety plan for Madeleine which was designed to keep Madeleine safe during school hours. The result of this failure meant Madeleine was able to leave school undetected and engage in a self-harm act which resulted in their admission to hospital. This failure possibly more than minimally contributed to Madeleine's death.<br><br>The lack of resources available to enable the timely allocation to Madeleine of a Tier 4 bed in a paediatric mental health facility possibly more than minimally contributed to Madeleine's death. |

| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Madeleine Savory was 15 years old when they died. Although not formally diagnosed with a mental health illness, at the time of their death clinicians were considering a working diagnosis of mood disorder depression of a severe nature. Madeleine had a very significant history of periodic suicidal ideation and a history of self-harm, the risk of both becoming acute in early February 2022. Madeleine was known to the Child and Young Persons Mental Health Service and to the Paediatric Ward at Ipswich Hospital. All organisations concerned with Madeleine's care had knowledge of their history of suicidal ideation.<br><br>On the 3rd February 2022 Madeleine absconded undetected from their school and carried out an act of self-harm which resulted in their hospitalisation. They were subsequently identified as needing a Tier 4 Bed admission on a paediatric mental health ward. Measures were put in place for such a bed to be sourced. At the time of Madeleine's death a bed was neither identified nor allocated to Madeleine.<br><br>During Madeleines admission on Bergholt Ward at Ipswich Hospital they were assessed as being a high risk of self-harm. Their mood fluctuated and on occasions Madeleine presented with no indication of either suffering from low mood or suicidal ideation. Throughout this period of time Madeleine's presentation was complex and reflected the working diagnosis of mood disorder depression of a severe nature. A risk assessment on the 12th February 2022 identified the need for additional measures in managing Madeleine's risk which included mental health observations. These measures were ceased on or around the 14th February 2022. The rationale behind why these measures were ceased is unclear.<br><br>On the 19th February 2022, during the evening Bergholt Ward shift, Madeleine appeared settled and an earlier episode of distress during the day seemed to have no further impact on them. At around 22:05 pm Madeleine made their way to the bathroom securing the door behind them. They were not observed by ward staff entering the bathroom and there was a period of up to ten minutes during which Madeleine's precise whereabouts was unknown. At around 22:20 pm the evening shift Nurse-in-Charge on Bergholt Ward was informed that Madeleine had been in the bathroom for at least ten minutes and was concerned that this period of time was longer than expected. Measures taken to rouse Madeleine by knocking on the door or calling out to them produced no response. Staff subsequently entered the bathroom and found that Madeleine had ligatured themself. Resuscitation efforts resulted in a return of spontaneous circulation and Madeleine was transferred to the Intensive Treatment Unit at Ipswich Hospital. However, Madeleine had suffered a fatal hypoxic brain injury and they sadly passed away on the 26th February 2022. |
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| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. I heard further evidence from the Interested Persons' at a separate hearing on 17th October 2023 in relation to these concerns.<br><br>At this hearing I received evidence from both East Suffolk and North Essex NHS Foundation Trust and Northgate High School concerning the measures they had put in place to address the failures identified during the course of the Inquest. I was satisfied that these measures addressed the concerns in relation to each of these Interested Persons and which had arisen from the Inquest. |

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| | I also received helpful evidence from the East of England Provider Collaborative concerning the measures which that organisation had undertaken in their area of responsibility to address my concern in relation to the availability and allocation of Tier 4 beds in a paediatric mental health facilities to children such as Madeleine.<br><br>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.<br><br>The MATTERS OF CONCERN are as follows.<br><br>The availability, nationally, of Tier 4 beds in paediatric mental health facilities to allow for the timely allocation to children in need of care in such facilities such as Madeleine Savory. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by January 10, 2024. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>**Family of Madeleine Eve SAVORY**<br>**East Suffolk and North Essex NHS Foundation Trust (ESNEFT)**<br>**Norfolk and Suffolk Foundation Trust (NSFT)**<br>**Suffolk County Council (SCC) (Children's Services and Madeleine Eve SAVORY's School)**<br>**East of England Provider Collaborative**<br><br>I have also sent it to<br><br>**(Legal rep. SCC)**<br>**(Legal rep. NSFT)**<br>**(Legal rep. ESNEFT)**<br>**(Legal Rep. Family)**<br>**(Legal rep. EofEPC)**<br>**(Family Solicitor)**<br><br>who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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** | **Dated: 15/11/2023** |

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| | **Darren STEWART OBE**<br>**HM Area Coroner for**<br>**Suffolk** |