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:** **United Children's Services via their legal representative.**
1	**CORONER** I am Miss I THISTLETHWAITE, His Majesty's Assistant Coroner for the coroner area of Leicester City and South Leicestershire.
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 12 August 2021 I commenced an investigation into the death of Ash BANNISTER aged 16. The investigation concluded at the end of the inquest on . The conclusion of the inquest was: Suicide The cause of death was established as: I a Hanging (suspension by a ligature around the neck) I b I c II
4	**CIRCUMSTANCES OF THE DEATH** Ash Bannister was a 16 year old who was assigned female at birth but became gender neutral, Ash wanted to be referred to as "they" or "their". Ash was born in Croydon in 2004 and had a very difficult start to life. Ash first became known to social services in 2005 after concerns were raised about Ash being exposed to drug use in the family home, [redacted] and physical abuse. Ash was subject to a Child Protection Plan and ultimately placed into foster care in 2006 due to concerns about neglect and the misuse of drugs at home. Ash remained looked after until 2007 when Ash returned to her father's care. Social care became involved again when Ash was around 10 or 11 years old. In January 2018 Ash's family confirmed they were no longer able to manage Ash at home and keep the rest of the family safe, Ash was therefore to move into a residential placement.

	Ash remained in residential care until she died on 7 August 2021. Ash was involved with multiple agencies throughout life and was a child with complex needs. Ash had multiple vulnerabilities including early neglect, a difficult childhood, the fact Ash was a looked after child, a history of exposure to Child Sexual Exploitation, mental health difficulties and a diagnosis of Autism Spectrum Disorder along with some potential difficulties around eating and exploration of their gender identity. Ash was first referred to Child and Adolescent Mental Health Services ("CAMHS") in around 2009 or 2010 at the age of 5 or 6 whilst living in Croydon. Ash had a long history of self-harming, this started at a very early age (9 years old) and was a theme throughout Ash's short life. Ash experienced both auditory and visual hallucinations. Ash would hear a male voice which told Ash that they were worthless, the voice would belittle Ash and encouraged self-harming. Ash was found hanging [redacted] at the residential care home (which was run by United Children's Services) where they lived on 7 August 2021. Ash was confirmed dead at 0922hrs by East Midlands Ambulance Service.
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: **Risk Assessments** I heard evidence to confirm that Ash was subject to a Ligature Risk Assessment which was put into place after Ash ligatured in December 2020, at that time the Risk was deemed to be a "*medium"* risk. The Ligature Risk Assessment was reassessed in April 2021 at which time the risk level was lowered to "*low*". I heard evidence to confirm that at some point between the April 2021 review and Ash's death a decision to remove Ash's personal Ligature Risk Assessment was made. United Children's Services were unable to tell me the date on which the decision to remove Ash's Ligature Risk Assessment was made because there is no documentation relating to the date on which that decision was made or the reasons why that decision was made. This lack of documentation is a grave concern. Ash died on 7 August 2021 from 1a) Hanging (suspension placing a ligature around the neck) there was no personal Ligature Risk Assessment in place at the time of death. **Documentation and communication** I heard evidence to confirm there was no documentation created by United Children's Services to detail the date on which Ash's Ligature Risk Assessment was deemed to be no longer required or to explain the rationale behind the making of that decision. There is no documentation to explain or justify the deviation from Ash's care plan on the morning that Ash died.

Further, the Court heard evidence to confirm that there was little or no communication of Ash's historic Child Sexual Exploitation risk between the two United Children's Services care homes when Ash moved from The Oaks to The Laurels in July 2020.

Lack of documentation and poor communication is a concern.

Waking Night Cover

I heard evidence to confirm that Ash had consumed alcohol on the evening of 5 August 2021. Due to appropriate concerns about the consumption of alcohol when on anti-psychotic medication staff at the residential care home implemented an "ad hoc" waking night process, this means that a member of staff remained outside Ash's bedroom door and awake all night. During the waking night period Ash went into the lavatory and made what are described as "superficial" cuts to her neck, a blade was later removed from Ash.

The next day, on 6 August 2021, staff described Ash as having a good day. Ash went to bed as normal at around 2150hrs. There was no ad hoc waking night cover implemented. Ash was not checked on from the time Ash went to bed at 2150hrs until 0900hrs on the 7 August 2021, a period of 11 hours. During those 11 hours Ash ended their life. Ash was found hanging [redacted] at 9am on 7 August 2021.

The decision to implement ad hoc waking night cover is not a decision which is governed by policy at United Children's Services. I heard evidence to confirm that the decision is based upon the gut instinct of the staff on duty at the time. The fact there is no policy to specifically deal with ad hoc waking nights means the decision making around the same will not be consistent and therefore the level of care provided to the children in the care of United Children's Services is heavily dependent on which staff member is on duty at the time that the care is needed.

Further, there is no step down process to wean children off ad hoc waking night cover. In Ash's case Ash went from having a staff member outside her door throughout the night from 5 to 6 August 2021 to having a period of 11 hours where Ash was entirely unsupervised throughout the night from 6 to 7 August 2021. It was during those 11 unsupervised hours that Ash ended their life.

Compliance with care and support plans

Ash had a "support plan" and I was told in evidence that support plans contain "crucial" information relating to residents.

Ash's support plan stipulated that Ash was to be checked on every morning at 7am. Ash was not checked upon at 7am on the morning of her death, this is a breach of Ash's support plan.

There was nothing documented in any of the records disclosed to the Court to explain why the support plan was deviated from on this occasion. I was told by care home workers that they would not expect to check on a teenager at 7am at the weekend in a normal family home. The residential care home where Ash was living was not a normal family home but a therapeutic home for children with complex needs. The evidence from the Operations Manager at United Children's Services who run the home was that Ash should have been checked on at 7am.

Ash's support plan was incorrectly deviated from without any documentation, explanation or justification as to why. This should not have happened.

Staff training

The Court heard evidence from one member of staff who worked at a United Children's Services

care home for a period of 4.5 months and did not know what Child Sexual Exploitation was.

The Court heard evidence to confirm that new staff members have 6 months to complete all of their training meaning it is possible to have staff members working with children with complex needs and vulnerabilities who do not have a full understanding of the spectrum of their needs due to not having completed all of their training yet.

United Children's Services Investigation policy and process

I heard evidence to confirm that United Children's Services do have an investigations policy, albeit that document was not disclosed to the Court despite a request for confirmation as to whether any internal investigation of any kind was undertaken and confirmation of what investigatory processes were available to United Children's Services to use after Ash's death.

I heard conflicting evidence at the inquest in relation to whether an investigation was undertaken by United Children's Services after Ash's death. I was told (1) there was no internal investigation but they did feed into the Local Authority's Safeguarding Investigation and (2) there was an investigation undertaken by United Children's Services but the outcome of the investigation was not documented.

I heard evidence from the Operations Manager at United Children's Services to confirm that the investigation which took place after Ash's death but which was not formally documented was discussed at the United Children's Service's Board Meeting around 6 or 7 months post death.

Ash died in August 2021, the Board Meeting will therefore have taken place in or around February or March 2022. I heard evidence to confirm that the required changes to the United Children's Services investigation policy and process were discussed at the Board Meeting but that at the time of the inquest, 2 years and 1 month after the Board Meeting and 2 years and 8 months after Ash's death, those changes had "not yet" been made. I asked why changes had not been made and was told that United Children's Services wanted to get the inquest process "out of the way" before making any changes. I have grave concerns about the fact that United Children's Services have been running homes in the knowledge that they have an inadequate investigation process in place for over two years.

Significant learning came to light at the inquest which United Children's Services were not aware of before the inquest.

It was accepted by United Children's Services that their investigation policy and process was not fit for purpose because it failed to identify all of the learning arising from Ash's death. If an investigation was undertaken by United Children's Services after Ash's death it:

(1) Was not documented;
(2) Failed to identify all of the learning uncovered at the inquest;
(3) Failed to trigger any changes at United Children's Services.

The investigation process in place at United Children's Services is therefore not fit for purpose.

Policies and processes at United Children's Services in general

I have concerns about policies and processes in place at United Children's Services, including the investigations policy, the policies governing risk assessments, in particular the ligature risk assessment, and the ad hoc waking nights process. I heard evidence at the inquest about United Children's Service's plan to make, what appear on the face of it, to be broad and wide-reaching changes to their policies and processes.

	However, at the time of writing this report those changes have not been discussed, finalised, implemented or embedded. The children in the care of the United Children's Services will, in my opinion, remain at risk until such time as appropriate and effective action is taken and the necessary changes are implemented and embedded at the company and within their care homes.
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 June 17, 2024. 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: [redacted], father and step-mother of Ash [redacted], mother of Ash The London Borough of Croydon Leicestershire County Council Leicester City Council Leicestershire Partnership NHS Trust I have also sent it to: OFSTED 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.
9	**Dated: 25/04/2024**  **Miss I THISTLETHWAITE**

	His Majesty's Assistant Coroner for Leicester City and South Leicestershire