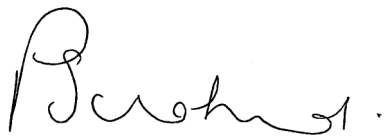
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** The Rt Hon Victoria Atkins MP Secretary of State for Health and Social Care 39 Victoria Street London SW1H 0EU
1	**CORONER** I am Penelope Schofield, Senior Coroner, for the coroner area of West Sussex and Brighton and Hove
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 29th April 2021 I commenced an investigation into the death of Axel Price aged 18. The investigation concluded at the end of the inquest on 9th October 2023. The overall conclusion of the inquest was a narrative conclusion which stated that:- "At some time between the 15th April and 23rd April 2021 Axel, who had recently turned 18 years old tied a ligature [redacted] It cannot be determined if at the time he had intended to end his own life. On 22nd February 2021 Axel had an unplanned discharged from Hospital, following his arrest by Police, at a time when he was showing signs of a decline in his mental health. The agencies failed him in that:- 1. The Mental Health services failed to arrange a coherent planned discharge on 22nd February 2021 and provide a clear risk, crisis, and care plan on discharge. 2. Adult Social Care failed to arrange a capacity assessment upon his discharge on 22nd February 2021 or anytime thereafter. 3. There was lack of consideration by all agencies involved with Axel as to whether the accommodation provided to him was suitable for a young person, whose capacity fluctuated when in crisis, and who in those circumstances became unsafe to live alone. 4. Axel's lead Practitioner failed to assertively engage with Axel after discharge and meet with him in person. She was therefore not able to assess his ongoing risk or recognise his mental health deterioration. 5. On 6th April 2021 following an obvious decline in Axel's mental health presentation there was a failure by Adult Social Care staff to arrange a full risk assessment and mental health review. 6. There was a lack of support and active engagement for Axel provided by the Adult Assessment and Treatment Service in Crawley pending his transfer to Adult Assessment and Treatment Service in Brighton. Axel's death was contributed to by neglect"

4	**CIRCUMSTANCES OF THE DEATH** At some time between the 15th April and 23rd April 2021 Axel, who had recently turned 18 years old tied a ligature [redacted]. Axel had recently been detained under Section 2 Mental Health Act 1983 but discharged following a violent incident in the hospital when he was taken into Police custody. He was released from Police custody into temporary accommodation in Brighton provided by Adult Social Care.
5	**CORONER'S CONCERNS** During 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: This case identified that there is a lack of clear understanding of the risk or accountability between the agencies when a young person transitions from CAMBS services at the age of 18 to adult services. The expert who provided evidence in this case said that this was a well-recognised problem and whilst services across the country had tried to address this, there was a lack of national guidance and provision. In this particular case Axel was particularly vulnerable. He was born Yasmin Price but identified as a male from a young age. He had struggled emotionally during his teens and had indulged with alcohol and drugs. He had been detained on a number of occasions due to his mental health. At the age of 18 he transitioned to adult services but there was a lack of a recognised pathway for him. In the lead up to his death he had been discharged from a mental health provision following his arrest for criminal offences. He was then discharged from the hospital and subsequently the Police station to temporary accommodation. There was little shared understanding between agencies of how Axel should best be supported and therefore he appeared to fall between the services. Substantial changes have been made locally by Sussex Partnership Foundation NHS Trust around the transition of those from CAMBS to Adult health services but looking at other Prevention of Future Death Reports this is not just a local issue. There is a lack of national guidance and support in relation to the multi-agency approach that is needed to support those young people transitioning to adult health and social care services. Unless this is addressed nationally, sadly other deaths will occur.
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 10th June 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:- **a) The family of Axel Matters (also known as Yasmin Price)** **b) Sussex Partnership Foundation NHS Trust** **c) East Sussex County Council** **d) Priory Group** **e)** [redacted] 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: 15/04/2024**  **Penelope SCHOFIELD** **Senior Coroner for** **West Sussex, Brighton and Hove**