REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Rt Hon Victoria Atkins MP** **Secretary of State Department of Health and Social Care** **39 Victoria Street** **London** **SW1H 0EU** **Right Hon Laura Farris MP** **Under-Secretary of State Victims and Safeguarding** **House of Commons** **London** **SW1A 0AA** **The Chief Executive Norfolk and Suffolk NHS Foundation Trust,** **Trust Headquarters** **Hellesdon Hospital** **Drayton High Road** **Norwich** **NR6 5BE.** **Suffolk County Council** **Head of Adult and Child Services** **Endeavour House** **8 Russel Road** **Ipswich** **Suffolk** **CEO of the NHS Norfolk and Waveney Integrated Care Board** **County Hall** **Martineau Lane** **Norwich** **NR1 2DH** **The Chief Constable** **Suffolk Constabulary Police Headquarters** **Portal Ave** **Martlesham Heath** **Ipswich** **IP5 QS**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 7th June 2023 I commenced an investigation into the death of **Katie MADDEN** The investigation concluded at the end of the inquest on 21st May 2024. The conclusion of the inquest was that the death was the result of:-

	Suicide, whilst the balance of her mind was disturbed. The medical cause of death was confirmed as: **1a Hanging**
4	**CIRCUMSTANCES OF THE DEATH** **Katie Madden was declared deceased on 4th June 2023 at the [redacted] in Suffolk.** **Kate had been found by a friend, hanging [redacted]** **Kate's friend had attended after not being able to contact her for a couple of days.** **Kate was diagnosed with anxiety, depression, and emotionally unstable personality disorder which made her act impulsively when faced with emotionally painful situations and stress.** **Kate had previously received a Claire's Law Domestic Violence Disclosure, and was known to be in a toxic relationship. Kate had historically and recently been the victim of domestic violence.** **Kate was known to both Mental Health Services, and Social Services, and her children were in care.** **Despite restrictions in place, Kate had argued with the subject of the Domestic Violence Disclosure just prior to her death. During the argument Kate was told to go and kill herself.** **Kate's toxic relationship, in conjunction with Kate's known mental health conditions, affected her state of mind and therefore contributed to her death.**
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters given 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** as follows. – **1. No evidence was seen that recipients of a 'Claires Law' Domestic Violence Disclosure are treated as being of greater vulnerability, or at a higher risk, when Child Services are undertaking investigations regarding the provision of children's care, and removal of the children from a parent is being considered. It was heard in evidence that the Social Worker appointed to this case, quite properly focussed on what was in the best interest of Kate's children. There was however no formal system in place to provide additional support for Kate herself, even though she was known to be vulnerable.** **2. It was identified that when Kate was informed there may be an application to the Family Court to place her children into care (using the Public Law Outline process), the impact of such a decision on her mental health, or physical wellbeing was not taken into consideration. As a recipient of a 'Claires Law' Domestic Violence Disclosure, it was**

	acknowledged that she was of greater vulnerability, but no system is currently in place which allows a risk assessment to be undertaken at the time the Public Law Outline notification is given to a parent. The day after Kate was told of the Public Law Outline notification, she intentionally crashed her car in an unsuccessful attempt to end her life, requiring 4 weeks in an Intensive Treatment Unit to recover from the serious injuries she received. **3. Once the Public Law Outline process was initiated, independent legal advice was provided, and a voluntary sector advocate supported Kate through the legal process. However, Katie received no independent support from Social Services, and had no independent professional to undertake a holistic review of her case, in light of her known circumstances and vulnerabilities. It was heard that mental health professionals had assumed Kate had a Social Worker of her own, and expressed surprise when finding out that she did not.** **4. Safeguarding referrals made the Multi-Agency Safeguarding Hub in respect of Kate's children were viewed in isolation, with no system in place to the assess any additional risks posed to Kate herself. There were no additional steps, or risk assessments undertaken in relation to Kate, even though she was a recipient of a 'Claires Law' Domestic Violence Disclosure and therefore known to be more vulnerable.** **5. In 2022 it was recognised by a Clinical Psychologist that Kate could benefit from Schema-based Cognitive Behavioural Therapy, which is not routinely available on the NHS.** **The psychological review had been ordered by the Family Court, and funding for this course needed to be applied for.** **Applying for funding involved requests to the Legal Aid Board, Integrated Care Board (Individual Funding Request), Wellbeing Service and Social Services, none of whom provided the funding, with each suggesting contacting one of the other agencies involved.** **An experienced mental health clinician with many years' experience described the 'whole route as very complicated' and 'it was difficult to find a solution for funding'. In addition, funding was very rarely made available, and as a service they were usually unable to meet patient expectations (who believe a treatment might be made available), where in reality it almost certainly would not be available.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 25th July 2024 I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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;- 1. Kate's next of kin. 2. Suffolk Safeguarding Partnership I am under a duty to send the Chief Coroner a copy of your response. 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**30th May 2024** **Nigel Parsley**