Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Department for Health and Social Care** **2 Department for Education** **3 NHS England**
1	**CORONER** I am Charlotte KEIGHLEY, Assistant Coroner for the coroner area of Cheshire
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 02 October 2019 I commenced an investigation into the death of Nathan Tesla George SCANTLEBURY aged 16. The investigation concluded at the end of the inquest on 15 July 2024. The conclusion of the inquest was that: Nathan Tesla George Scantlebury died as a consequence of asphyxia following a [redacted]. The [redacted] event was a deliberate act but it cannot be established on the evidence that he intended the outcome to be fatal. Nate's death was contributed to by:- i. A failure to take appropriate steps to ensure Nate's safety when the [redacted] was first observed and whilst it was still loose; and ii. Neglect Nate's death was possibly contributed to by:- i. The lack of availability generally of suitable placements for children with complex mental health needs. ii. Failures by the Local Authority and the Clinical Commissioning Group to adequately assess the suitability of the placement to meet Nate's needs; iii. A lack of understanding by the local authority and the clinical commissioning group of the way in which the model of care used in the placement worked in practice and whether this would meet Nate's needs. iv. Failings by the clinical commissioning group and the local authority to ensure that a s117 after-care plan was in place to ensure that all professionals involved in Nate's care were aware of their respective role and responsibilities
4	**CIRCUMSTANCES OF THE DEATH** Nathan Scantlebury was just 16 years old at the time of his death. He had a complex mental health needs and was a looked after child, having been so since December 2013. Nate had a significant history of self-harm and spent several periods detained under the Mental Health Act. Nate had previously been placed at a placement in Wales, specialising in providing care to Young People with high risk self-harming behaviours. Following a serious incident in August 2018, Nate was detained under the Mental Health Act with the placement

	considering they could no longer keep him safe. Following a period of detention, the only placement available for Nate was in a mainly adult service, with a least restrictive approach adopting a therapeutic risk-taking and recovery-based approach. The service provided care for those aged between 16 and 25. During the course of Nate's placement, a number of concerns were raised in respect of the suitability of the service for Nate, with a number of self-harming incidents taking place which required hospital treatment. On the 25th September 2019, Nate tied a [redacted] around his neck, initially the [redacted] was loose and Nate was left whilst advice was obtained. Nate was later found laid on his bed, blue in colour and unresponsive with the [redacted] tight around his neck. The [redacted] was removed and Nate's physical observations taken with further advice being sought and observations taken prior to an ambulance being called. Nate was taken to hospital and pronounced deceased a short time later.
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: The lack of availability of suitable placements for high risk children with complex mental health needs which is both a local and a national issue which has been ongoing for a number of years.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 September 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] [redacted] **Liverpool City Council** [redacted] **Cheshire and Merseyside Integrated Care Board (Liverpool)** I have also sent it to **Child Safeguarding Practice Review Panel** 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: 23/07/2024**  **Charlotte KEIGHLEY** **Assistant Coroner for** **Cheshire**