Re : Jennifer Sharren Chalkley, Deceased

Regulation 28 Report to Prevent Future Deaths

	Regulation 28 Report to Prevent Future Deaths This Report is being sent to: **1. [redacted], Secretary of State for Education, The Department for Education (in relation to Concerns 1 and 2)** **2. [redacted], The Chief Executive Officer of Surrey County Council (in relation to Concern 1)**
1	**CORONER** I am Richard Travers, HM Senior Coroner for Surrey.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** I commenced an investigation into the death of Jennifer Sharren Chalkley. The inquest concluded on the 1st May 2024 when I found that the medical cause of death was: Ia Suspension and my conclusion as to the death was that: Jennifer Chalkley died as a result of Suicide. Her death was more than minimally contributed to by : (i) A failure by Surrey and Borders Partnership NHS Foundation Trust's Child and Adolescent Mental Health Service properly to assess, diagnose and treat Jennifer following referrals made in May 2018 and January 2021 in order to manage her conditions and minimise her risk of suicide, (ii) A failure by Surrey County Council's Special Educational Needs Department to ensure that Jennifer's Education, Health and Care Plan contained sufficient and updated information about her mental

	and emotional health needs and her risk of suicide, such as to enable the college she attended from September 2021 to understand and meet her consequential needs and manage the consequential risk, and (iii) A multi-agency failure to share information and work together to ensure that Jennifer was supported effectively to manage her neurodevelopmental and mental and emotional health needs, and her risk of suicide, especially from June 2021 onwards. I subsequently held a hearing to receive evidence relating to the prevention of future deaths and this was concluded on the 26th July 2024. I then allowed time for submissions by Interested Persons.
4	**CIRCUMSTANCES OF THE DEATH** When she died, aged 17 years, Jennifer Chalkley was a girl with complex special needs. She had been diagnosed with Attention Deficit Hyperactivity Disorder when she was 10 years of age and Autistic Spectrum Disorder when she was aged 11 years. These two neurodevelopmental conditions, together with associated excessive anxiety, low mood, and emotional dysregulation from which she suffered periodically, resulted in a persisting but fluctuating risk of suicide. Jennifer was known to the Child and Adolescent Mental Health Service and to Children's Services, having been the subject of a number of referrals arising from her suicidal ideation and behaviour and her other vulnerabilities. She was also monitored under the Paediatric Team at a local hospital. An Education, Health and Care Plan was issued to Jennifer by the Special Educational Needs Department of her local authority when she was 15 years old, but she struggled to cope in mainstream school and experienced the breakdown of school and college placements. Jennifer also struggled to cope with personal relationships. In September 2021, Jennifer enrolled in a course at a new college. Within weeks she experienced low mood and was expressing suicidal ideation. Late on the evening of the 11th October 2021, Jennifer returned to her mother's home, having separated from the boyfriend with whom she had been living. On the 12th October 2021, Jennifer's mother feared that she was suffering a mental health crisis and arranged an emergency telephone consultation with the General Practitioner for later that day. However, at 16.20 hours, Jennifer was found hanging [redacted] in her bedroom. Despite resuscitation efforts from attending paramedics, she could not be revived and her death was pronounced at 16.40 hours on the 12th October 2021. Full details of the events and failings which lead to Jennifer Chalkley's death are set out in my "Findings and Conclusions" document, a copy of which is sent with this report.

5	**CORONER'S CONCERNS** The evidence received at the prevention of future deaths hearing showed that a number of the issues and concerns raised at and following the inquest hearing have been addressed. However, in my opinion the following concerns remain and give rise to a continuing 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: **<u>Concern 1</u>** The "Special Educational Needs and Disability Code of Practice: 0 to 25 years", which was issued by the Department for Education and the Department of Health and Social Care, provides statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities. The Code indicates that Local Authorities must carry out their functions with a view to identifying all the children and young people in their area who have or may have SEN or who have or may have a disability (Section 22 of the Children and Families Act 2014). At the inquest hearing, I heard that such children and young people must be identified as soon as possible so that their needs can be assessed and met as soon as possible. This is because the early provision of support increases its effectiveness and the meeting of need at the earliest stage may prevent, and is likely to reduce the risk of, mental health difficulties and suicidality developing. The evidence at the inquest revealed that there was some delay in an application being made for Jennifer to be assessed for an Education, Health and Care Plan because the mainstream school she attended believed that, before making such application, it must first have spent an additional £6,000 per annum in meeting her needs. The evidence suggested that this belief was wide-spread amongst schools, colleges and others, both in and beyond Surrey. At the prevention of future deaths hearing, it was confirmed that there is no statutory or other requirement for a school to have to spend an additional £6,000 per annum in meeting a child's SEN needs before applying for a statutory assessment. I am concerned that the misunderstanding by schools and colleges is delaying or preventing applications for statutory assessments being made in some cases and thereby acting as a barrier to ensuring all children and young people with additional needs are receiving effective support as soon as possible. I am concerned that this creates or increases the risk of avoidable suicidality developing. I heard that, in response to this misconception, Surrey County Council has, since Jennifer's death, updated its guidance on the criteria that will be considered to determine when a statutory assessment will be conducted and that the new guidance seeks to make it clear that there is no requirement for £6,000 to be spent before an application for assessment can be made. However, the evidence I

received from a local college showed that the misunderstanding persists, despite the updated guidance. It seems therefore that further action is needed to ensure that all Surrey schools and colleges understand, clearly, that spending an additional £6,000 on a child is not a pre-requisite to applying for a statutory assessment.

I heard too that this misunderstanding probably originates from the School and Early Years Finance (England) Regulations 2023 (and their previous iterations), which set the high needs costs threshold at £6,000; it seems that the confusion may also stem from information issued by the Education and Skills Funding Agency.

I am concerned that the misconception persists nationally and that, for the reasons set out above, action is needed to ensure that all schools and colleges understand, clearly, that spending an additional £6,000 on a child is not a pre-requisite to applying for a statutory assessment.

Concern 2

At the inquest hearing the evidence showed that in September 2021, shortly before her death, Jennifer commenced a course at a new college. I heard that the new college did not receive her safeguarding file from her previous educational establishment prior to her death on the 12th October 2021; as a result the new college's ability to recognise and manage Jennifer's needs and risks, including her risk of suicide, was undermined.

I heard that the Keeping Children Safe in Education 2024 statutory guidance for schools and colleges, and its previous iterations, state that where children leave a school or college, the designated safeguarding lead should ensure that their child protection file is transferred to the new school or college as soon as possible, and within 5 days for an in-year transfer, or otherwise within the first 5 days of the start of a new term, to allow the new school or college to have support in place for when the child arrives.

I am concerned that the requirement to transfer safeguarding information "within the first 5 days of the start of a new term" means that a child who is at risk of self-harm or suicide may start at a new school or college without that establishment having all or any of the information in the safeguarding file. As that information is likely to be relevant to their management of the risk, I am concerned that permitting transfer up to five days after the start of term undermines the stated intention that the new school or college should "have support in place for when the child arrives".

I also heard that there is no centralised system that stores and transfers learning support and safeguarding information between schools and colleges, or other agencies who are supporting young people. Rather, the transfer of documents is undertaken by the individual schools and colleges concerned, with, I heard, variable levels of efficiency and reliability.

	In the circumstances, I am concerned that there is not a national system in place to require and facilitate the guaranteed transfer of safeguarding information in advance of a child or young person starting a new school or college at the start of a new term or academic year, and that this exposes a suicidal child or young person to additional and avoidable risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing the concerns set out above and I believe your organisation has 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 the 9th December 2024**. I, as 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: (i) [redacted] (ii) [redacted] (iii) Surrey and Borders Partnership NHS Foundation Trust (iv) Guildford College (v) Nescot College (vi) Howard of Effingham School and the Howard Partnership. I am also under a duty to send a copy of your response to the Chief Coroner. I may also send a copy of your response to any other 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	**14th October 2024** **Richard Travers**