In the South London Coroners Court

Inquest touching the death of Liam Hardy

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **David Bradley, Chief Executive, South West London and St George's Mental Health Trust**
1	**CORONER** I am Selena Lynch, Senior Coroner for the South London Area
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 the 13th June 2014 I concluded an Inquest into the death of Liam Hardy, a 15 year old schoolboy. The medical cause of death was hanging, and I recorded a narrative conclusion as follows: At about 9 pm on 19th November 2012 at his grandfather's home (*address redacted).*Liam became upset and agitated while exchanging text messages. He tied his school tie around his neck and attached the other end to the upper part of a bunk bed. He sat on the lower bunk and the ligature caused him to lose consciousness. On the balance of probability he did not intend to die. His actions were in part because his complex behavioural and emotional problems were not adequately or appropriately assessed or managed by social and mental healthcare services, and the risk to his life by acts of self harm was not recognised or adequately managed. There were failures to fully share or access information, and significant events were not dealt with in a timely fashion or at all. The services placed too much reliance on addressing his needs through the family therapy service who failed to acknowledge that their intervention was not effective in addressing Liam's needs. Other agencies did not appreciate the role and limitations of the family therapy service with the consequence that alternative and/or additional measures to protect Liam were not fully explored or considered.
4	**CIRCUMSTANCES OF THE DEATH** Please see the conclusion set out in paragraph 3. Further information can be provided if required.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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 nurse who assessed Liam after an episode of self harm was unaware of some of the significant events in Liam's history. She explained that the RiO system (an

	electronic patient record system used in many Trusts) did not flag up or summarise such events or primary concerns and issues in a single place, and there was insufficient time to read all of the notes (which might be voluminous) before seeing a patient. Had she been aware of the full history her actions may have been different in Liam's case, but her comments about the RiO system were general, and the difficulties are apparently encountered even today.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 **28th August 2014**. 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 • The family of Liam Hardy • Sutton and Merton Community Servies • London Borough of Sutton • Carshalton Boys School • Epsom and St Helier NHS Trust and to the Local Safeguarding Board. I am also 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Selena Lynch **2nd July 2014** **Selena Lynch, Senior Coroner**