REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

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1	**CORONER** I am Miss Joanne Kearsley, Area Coroner for Manchester South District.
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. http://www.legislation .gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION AND INQUEST** On the 5th December 2013 I commenced an investigation into the death of Kesia Lena Mary Leatherbarrow aged 17 years. The investigation concluded at the end of the Inquest on the 6th February 2015. The Conclusion recorded was a narrative conclusion indicating that, on the 3rd December 2013 at [redacted] the deceased died as a result of tying a ligature around her neck. There is not sufficient evidence to indicate that she was intending to end her life. The deceased had moved to the Manchester area on the 26th October 2013 since when she had interactions with a number of agencies. There had been missed opportunities for agencies to obtain and collate information, to carry out adequate assessments of the information they held and to consider appropriate levels of support. Despite these failings there is not the evidence to say on the balance of probabilities that any of these matters caused or contributed to her death.
4	**CIRCUMSTANCES OF THE DEATH** **I do not propose to detail the significant evidence that was heard in this case save to say that the brief circumstances were as follows:** The deceased had always resided with her family in the Lancashire area. There had been increasing concern about her behaviour including her drug use, her abusive and aggressive outbursts, self-harming and her mental health. She had spent a month in July 2013 in the Platform facility in Preston, Lancashire. This is a mental health facility for young people. Upon her discharge matters deteriorated and on the 25th October Kesia was arrested by Lancashire Police. Her behaviour whilst in custody was concerning but she was not deemed to require sectioning under the Mental Health Act. Following her release from custody on the 26th October she threatened to jump from a bridge. The same day she went to live with her Father in the Tameside area of Manchester. Kesia had had little contact with her Father and he was not aware of all the recent issues and concerns surrounding Kesia.

From this point onwards Kesia had little contact with her mother and step-father who understandably had been severely impacted by the difficulties they had faced with Kesia.

Due to concerns about her behaviour whilst she was in police custody in Lancashire, Lancashire Constabulary raised a safeguarding report to the Multi-Agency Safeguarding Hub (MASH) which led to a referral to Lancashire Children's Services. This referral indicated that Kesia was a high risk and likely to self-harm.

Given that Kesia was now residing in the Tameside Area the referral was then forwarded by Lancashire Children's Services to Tameside Children's Services.

Upon receiving the referral only part of the information provided by Lancashire was then cut and pasted onto Tameside's own Referral Form which was inputted onto the computer system. There was therefore incomplete information on their own form although the Lancashire form was also scanned onto the Tameside Computer system.

When the case was reviewed not all of the information was considered as only the incomplete Tameside form was ever read. A decision was taken not to open a file and conduct a social work assessment for Kesia but to send a referral to the Child Adolescent and Mental Health Service (CAMHS).

Upon receipt of this referral Pennine NHS Foundation Trust assessed the information provided by Tameside and sent the referral to the administrator of the service for an appointment to be sent to Kesia. No appointment had been sent to Kesia at the time of her death.

As a result of her arrest in Lancashire, Kesia was before the Magistrates Court in Preston on the 5th November 2013. She received a referral order. Lancashire Youth Offending Team attended court and noted Kesia's new address in Tameside.

However the case, which was then considered by at least 4 people in the Lancashire Youth Offending Team, was not transferred over to the Tameside Youth Offending Team at all prior to Kesia's death. On four occasions there was a failure to notice the new address for Kesia which was clearly marked on the documentation on the file.

This meant that the referral order assessment and panel process was not commenced and concluded within the national guidelines prior to her death. There was also inappropriate thought given to breaching Kesia for non-compliance of her referral order.

From the 26th October 2013 (whilst in the Manchester area) Kesia, on at least 8 occasions prior to her arrest on the 30th November, had some interaction with officers from Greater Manchester Police.

On one occasion she was reported as missing from home by her Father; she

was located the
following day residing with her boyfriend at the Armadale Road address.

On two occasions Kesia made calls to the police with allegations of domestic violence against her by her boyfriend.

On another occasion she made a report of an assault against her by the ex-partner of her boyfriend.

On the 25th November Kesia attended at her Mother's home in Lancashire where she was aggressive, threatened to push her grandmother down the stairs and had hold of a knife whilst threatening to self-harm.

Officers from Lancashire Constabulary attended, Kesia was calm at the time of their arrival and she was taken back to her Father's house by her Grandmother. Her Father was not provided with information as to the exact nature of what had occurred.

Lancashire Constabulary made a further referral to their MASH which assessed Kesia as a Medium Risk.

Following her move to the Manchester area the Inquest heard evidence which indicated that from shortly after the 26th October Kesia was not in fact residing at her Father's. She was in reality spending a lot of time residing with her boyfriend and also staying in other accommodation.

On the 30th November Kesia was arrested in Manchester by Greater Manchester Police for criminal damage and possession of cannabis. Shortly after her arrest and before her arrival at the police station, Kesia's presentation changed and she was extremely abusive and aggressive.

She remained in police custody, for reasons set out below, until the Monday morning when she was placed before the Court.

Her behaviour whilst in custody was of concern to custody staff and on two occasions police requested the attendance of medical professionals from MEDACS.

Whilst in custody, at the time of the first medical assessment, Kesia made a threat to jump off a bridge if she was released from custody. This was documented on the Risk Assessment Form on the custody record. A full risk assessment was not completed on her arrival into custody nor at any stage during her time in the police station.

Following her initial assessment by MEDACS there was a reasonable assessment made that Kesia was intoxicated and a decision taken to allow her time to sleep and potentially sober up. The Inquest heard evidence that the first nurse was not able to complete her assessment of Kesia at this stage.

A second assessment by MEDACS was conducted sometime later. The

	Inquest heard evidence about this assessment and also viewed the CCTV footage. The Inquest found that this assessment was incomplete and fell well short of being a meaningful assessment. In addition the Inquest heard evidence as to whether MEDACS should be able to access records held about an individual if they had been assessed by their staff in a different police force area. When assessed in Manchester by MEDACS access to her Lancashire MEDACS records would not have been possible as her name had been entered as unknown and not updated. During her interview and subsequent time in custody Kesia's behaviour remained concerning. A decision was taken not to bail Kesia but to keep her in custody in part due to the concerns officers had about her safety. The Inquest heard evidence as to the legislation surrounding 17 year olds in custody and additionally the availability of PACE beds for children in custody. Whilst in custody Kesia had access to an appropriate adult. The request for an appropriate adult was made by Greater Manchester police to Tameside Social Services. A form was then sent to the volunteer who attended the police station. In Manchester the volunteer Appropriate Adult Scheme is run by the Police and Crime Commissioner (PCC). The form completed by the appropriate adult should then be faxed back to Social Services. This did not happen. Information about the threat Kesia had made to jump off a bridge was passed to the Crown Prosecution Service (CPS) by way of the MG7 but it was not noted on the Prisoner Escort Record. At Court Kesia was seen by her solicitor, Tameside Youth Offending Team and GEO Amey staff before her appearance in Court. At no stage did they become aware of the threat Kesia had made whilst in police custody as this was known only to the CPS. No remand application was made therefore the CPS did not place the information as to her threat before the Court. Whilst being held at the Magistrates Court Kesia's behaviour caused concern. Bail checks on appropriate addresses were not carried out. Kesia was released with a bail condition of residence at her Father's address. She left court and went to her boyfriend's address where she stayed the night. She was found later the next morning in the garden of the property having tied a ligature around her neck.
5	**Coroner 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:-

GOVERNMENT

Legislation and the provision of Local Authority Accommodation

1. The Inquest heard evidence that recent changes to legislation means that whilst in custody 17 year olds are now treated as children for the purposes of the Police and Criminal Evidence Act (PACE). However the failure to make legislative changes to the supporting legislation means that for 17 year olds there is an anomaly in the system particularly around the provision of accommodation for a 17 year old who is refused bail. For these purposes a 17 year old is still classed as an adult and not a child and therefore there is no requirement for local authorities to provide accommodation. This would require primary legislation.

   There remains no legal requirement for local authorities to provide accommodation for 17 year olds who will then have to remain in police custody if bail is refused. The result is that 17 year old children risk being kept in custody for longer than necessary if there is nowhere suitable for them to be bailed to.

2. In addition the Inquest also heard evidence as to the reality of the situation in practice and the availability of such accommodation for those children to whom the law currently does apply i.e. 16 years and younger. The Inquest heard that across Greater Manchester it is estimated that, until recently, in only 10% of cases where the police requested such a service from a local authority a bed was available. Attempts are being made to address this issue but at present the figure remains at approximately 20% and the Inquest heard evidence that this was, "not good enough".

   Again the facts heard at this Inquest seem to suggest that children younger than 17 are at risk of being held in custody longer than necessary due to a lack of appropriate facilities. The court heard evidence that the police are in the undesirable position of having to decide whether to detain someone (potentially unlawfully) or release them when they feel it may be unsafe to do so.

3. It was clear throughout the Inquest that the legislation relating to 17 year olds presented challenges to those professionals who had contact with Kesia. For the purposes of safeguarding and the Children's Act she remained a child, being someone under the age of 18. Equally, however, she was old enough to consent to be in a sexual relationship. The Court was left with little doubt that the differing legislative provisions for 17 year olds pose unique challenges for professionals in

dealing with people of this age.

ACPO NATIONAL POLICE ISSUE

Exit Risk Assessments

1. The Court heard that since Kesia's death Greater Manchester Police have implemented a system to try and ensure that this situation does not happen again. It was therefore decided to hold a joint medical and police exit risk assessment when someone who has displayed self-harm ideation or behaviour leaves custody.

   Initially this was introduced for people aged 17 and under but as of January 2015 it was extended to all people leaving custody.

   Whilst this has been a significant commitment from Greater Manchester Police and has required the funding for an additional Doctor the Court heard evidence that so far this risk assessment has been conducted on over 144 people leaving custody.

   This is clearly capturing a large number of people who are displaying signs of similar behaviour or thoughts as Kesia did whilst in custody and the Court heard that a joint medical and police risk assessment on their exit from custody is essential in trying to ensure appropriate support when they leave the police station.

LANCASHIRE YOUTH OFFENDING TEAM AND TAMESIDE YOUTH OFFENDING TEAM

1. The Court heard evidence as to the poor understanding and communication between the Youth Offending teams of Lancashire and Tameside following Kesia's re-location to the Manchester Area. There was a failure by Lancashire to note her move which led to a delay in her case being transferred, but in addition there was a failure in the communications with Tameside for each team to understand what was being requested and to have oversight of the situation. This led to a lack of involvement with Kesia and a proposal to breach her. It also meant that no effective work was being carried out with her and a missed opportunity to recognise her developing situation in terms of her lack of residence and drug use.

GREATER MANCHETSER POLICE

Safeguarding Responsibilities

1. The Inquest heard a great deal of evidence from officers as to their

understanding and actions. No intelligence was placed on Kesia's nominal profile despite a number of concerning contacts with her by officers. It is a core function of the police to submit such intelligence.

2. Greater Manchester Police has no stand-alone safeguarding policy for matters which are not criminal. There is no clear guidance to officers regarding what to do to raise safeguarding issues. There is no process for the recording of safeguarding concerns. There is confusion and a lack of understanding as to which agencies officers should refer to and where this should be recorded. The fact that there was no record of Greater Manchester Police's involvement with Kesia, despite her having been reported missing from home, information about drugs, self-harm and being in a relationship with a much older individual did not flag-up one safeguarding referral to another agency was concerning.

Force Wide Incident Notices (FWINS)

1. There were a number of reported incidents relating to Kesia and her involvement with Greater Manchester police which necessitated the opening of a FWIN. The Court heard evidence as to the failure to pass on complete information to the officers who then subsequently attended on Kesia including on one occasion the fact that it had been communicated that she had a knife. The court heard evidence that the failure to pass on important information could impact on the safety of the officers and others and also lead to missed opportunities for safeguarding.

Closing Codes for Domestic Violence Incidents

1. Evidence was heard that when a FWIN is closed a code is attached to it. For domestic violence incidents the closing code relates to people over the age of 16 as being adults. This means that the case is not then automatically passed through to the Child Protection Team within Greater Manchester Police for a review even if one of the people involved is still a child - i.e. is 17 years of age.

   Whilst the case would still be considered by the Public Protection Investigation Unit however the availability for the child protection unit to have all the information relating to children may be beneficial.

Checks carried out by Public Protection Investigation Unit

1. Evidence was given to the Court that when a Domestic Abuse, Stalking and Harassment form (DASH) is submitted to the PPI unit, where the risk level is standard then no checks on the Police National Computer or the Police National Database are carried out. The rationale for this was not clear although DC Evans indicated this may be due to the volume of work. Clearly the PNC can hold vital information about a potential offender.

Custody Handovers

1. The Court heard evidence that the handovers which ensure that custody officers taking charge for detainees and their welfare have to conduct such handovers in their own time. The system at present relies on officers and staff attending work early and sometimes staying late after a 12 hour shift to provide a handover. Whilst it is clear there would need to be some overlap in the times people are on duty, the Court heard evidence as to the quality of the handovers which is clearly impacted by the fact that this crucial part of the information sharing process relies entirely on the free-time of officers and staff.

   The Court was advised that the provision of custody within GMP is currently under review but at present the position remains as it was in 2013.

Completion of the Prisoner Escort Record

1. The Prisoner Escort Record form was completed over 12 hours prior to Kesia leaving police custody. It was not checked or amended prior to her release and it failed to contain crucial information indicating that whilst in custody Kesia had made a threat to jump from a bridge. This should have been included.

GREATER MANCHESTER POLICE AND PENNINE CARE NHS FOUNDATION TRUST

Tameside Diversion Project

1. The Court heard evidence regarding a project in Tameside similar to one in Newcastle the aim of which was apparently to divert young people from the Criminal Justice System. However the Court heard that the Tameside Youth Diversion Project is not working as intended. The plan being that once someone is arrested there should be consideration to diverting the young person away from the Criminal Justice System if there is evidence of emotional disturbance / self-harm, etc. The court heard evidence that in Tameside this signposting is only taking place to the mental health services once the young person has been processed through the Criminal Justice System and is not in fact acting as a diversion pathway. There was no evidence from those working in custody that any consideration was given to this scheme for Kesia and there appeared to be little knowledge of the scheme. On the face of the evidence the current system appeared to duplicate the work carried out by the 16-19 Mental Health Service.

GREATER MANCHESTER POLICE / POLICE AND CRIME COMMISSIONER AND LOCAL AUTHORITIES

Appropriate Adult Scheme:

These concerns relate solely to the Appropriate Adult Scheme.

During the course of the Inquest the Court received a copy of the Protocol in place between the Police and Crime Commissioners Office, the Local Authorities and the Police. Evidence was heard from the Social Worker who received the call from GMP requesting an Appropriate Adult for Kesia and the Appropriate Adult who attended.

1. The evidence of the Social Worker was that until the commencement of the Inquest she was not aware and had not had sight of the Protocol document. It was her understanding that in all cases except for murder/rape and terrorism offences that an Appropriate Adult from the volunteer scheme would attend. It was not her understanding of the system in place that she should be assessing the information given to her by the police to consider whether it was more suitable for the attendance of a Social Worker. She indicated that if she had been aware of this she would have made further enquiries as to how Kesia was presenting in custody in order to make that assessment.

   She also indicated that when she was contacted by Greater Manchester Police no concerns at all were raised as to how Kesia had been in custody (at this stage she had been in custody for over 12 hours). She was not advised that Kesia had been assessed as intoxicated on arrival, nor that she had been seen by MEDACS, nor that she had threatened to jump off a bridge on her release. She indicated that if she had been aware of these matters she would have asked her colleague social worker who was also on call and who was an approved Mental Health Social Worker to attend as the Appropriate Adult.

   The Court heard evidence that following her attendance the appropriate adult completed the relevant form which would normally be faxed back to Social Services by Greater Manchester Police Officers. It was her understanding that this was the responsibility of Greater Manchester Police and that she also thought that on receiving the form Social Services may want to, " do something further possibly have proper metal health assessment on Kesia".

   Evidence from Tameside Social Services indicated that they did not receive the completed form in relation to Kesia and that it was not unusual not to receive the completed forms in any cases.

   Whilst the Court was informed that the PCC have facilitated the availability of equipment to Greater Manchester Police so that the form can be scanned back to Social Services, there was nothing in the protocol document which placed the responsibility for the return of this form on the Custody Staff. Nor was any evidence presented that

Custody Staff had been made aware that this was their specific responsibility.

Having heard the evidence It seems that the Custody Staff can be very busy and the passing of this responsibility to them is onerous. Allowing the Appropriate Adults to use the relevant equipment themselves before they leave to ensure that they fulfil their responsibilities is one thing, but the complete abrogation of responsibility from the Appropriate Adult to Custody Staff who have no role save to telephone social services requesting an Appropriate Adult is entirely different. Indeed given the independence of the Appropriate Adult and their role it may also be a conflict.

Similarly the Court heard evidence as to the signing of the Appropriate Adult Form by the Custody Sergeant. It was confirmed in evidence by Sergeant Simpson that his understanding is he signs the form so as to confirm what time the Appropriate Adult finishes dealing with the detained person. It is not his role to oversee the quality of the work and advice given by the Appropriate Adult.

Again there did not appear to be anything in the protocol to suggest that this was a responsibility which had been accepted by Greater Manchester Police.

The quality of the information given by the appropriate adult on the completed form was insufficient in light of all the information which had been made available to her about Kesia and the behaviour she had witnessed. Important information such as the threat made by Kesia was not placed onto the form which in correct circumstances should have been passed onto social services for their consideration – particularly given that Kesia was a child and there were obvious safeguarding concerns.

2. For children in custody where there are significant concerns as to their behaviour and risk to themselves and no family members have been identified as suitable Appropriate Adults (or who will not attend) consideration should be given as to whether the Appropriate Adult should in all cases be a social worker.

MEDACS

1. The Court heard and saw CCTV evidence of the second medical assessment which was conducted on Kesia. It was the Court's view that this fell far short of what was expected in order to reach any conclusions as to the fitness and wellbeing of Kesia. It was clear that a medical assessment could not be completed and in these circumstances this should be fully explained to the police and the record endorsed accordingly rather than simply endorsing that someone is fit to be detained/interviewed or transferred.

2. The Court also heard evidence that the same medical assessment is carried out for every detained person in custody regardless of whether that is a 17 year old child with mental health difficulties or a 69 year old man with a heart condition. There is no difference in the mental health assessments for children as opposed to adults. Consideration should be given as to any different requirements for the assessment of children, who by nature of the fact that they are in a police station are in a particularly difficult and vulnerable situation.

3. Similarly the Court heard that no safeguarding referral was made about Kesia despite information about her self-harming, drug and alcohol use.

MEDACS and GREATER MANCHESTER POLICE

1. The Court heard evidence as to the reasons why Greater Manchester Police requested the attendance of MEDACS. It was apparent to the Court that the expectations of the police as to the precise medical assessment being carried out and the conclusions of the assessment may not always be the same as the expectations and understanding of MEDACS. So for example the police may consider they are requesting MEDACS for a mental health assessment and the assessment in reality may simply assess whether the individual is fit to be detained. There needs to be greater understanding between the police and MEDACS as to what the assessment has consisted of and what it has concluded and how.

2. In addition, prior to a medical assessment taking place, there should be a full record made as to what information MEDACS staff have had access to. The Court heard evidence in this case that on some occasions a copy of the custody record may be physically available for MEDACS staff but there was no clarity as to whether this included previous risk assessments, whether this was a complete record and there was no recorded evidence to indicate what information had been passed to MEDACS by the police and who had provided the information.

CROWN PROSECUTION SERVICE

1. Whilst recognising that the CPS do not have the same safeguarding responsibilities they had clear evidence as to the threat that Kesia had made and this was not put before the Court nor passed on to any other agencies. Nor was any additional information sought from GMP. There was a lack of understanding between GMP and the CPS as to how such important information should be shared between agencies.

PENNINE CARE NHS FOUNDATIONS TRUST / TAMESIDE YOUTH OFFENDING TEAM and MEDACS

1. The Court heard evidence about two matters involving Mental Health

Services and other agencies. [redacted] gave evidence that in his view there would be interaction between their service and Tameside Youth Offending Team with regards to Kesia. This would either be done once the case had been passed to Amy Valentine or if Tameside YOT contacted their service. This did not occur as the file had not been processed at the time of Kesia's death but also because of the confusion between the Youth Offending Teams involved with Kesia which meant she was never picked up by Tameside. The plan that Kesia should be monitored for any interim changes in her risk did not therefore occur.

GREATER MANCHESTER LOCAL AUTHORITIES AND GREATER MANCHESTER POLICE

Multi- Agency Safeguarding Hubs

1. The Court heard evidence as to the effective working in Lancashire County Council and Lancashire Constabulary of the Multi-Agency Safeguarding Hub (MASH). It was clear from the evidence that the interactions Lancashire Constabulary Officers had with Kesia led to a simple, effective means of passing on safeguarding information to the MASH. This was not the system in Manchester and the Court heard evidence that the development of MASHs across Manchester is still ongoing. The Court heard evidence that in Manchester different hubs work differently with different agendas – some relate to domestic violence only and not all of them deal with safeguarding of children. The Court was advised that the plan is that by the end of the year across Manchester there will be fully operational safeguarding hubs but that each different local authority wants to go about it in a different way. This will mean that there is a lack of consistency in approach across the different local authorities in Manchester as to what will be dealt with. Worryingly some will not deal with the safeguarding of children and such an approach may lead to a lack of consensus and understanding of their roles. In addition such an individual approach will need careful understanding by other agencies as to what can be referred and what cannot – potentially exacerbating an already difficult and confusing situation.

ALL AGENCIES

1. Having heard the evidence the Court felt that there was a degree of confusion and misunderstanding between all the agencies as to their roles, what they are able and not able to do and also where to access important and effective information. By way of brief examples, when Kesia was in custody MEDACS contacted the Crisis Team to see if Kesia was known to them, Kesia had never been involved with the Crisis Team. There was no contact made with the Mental Health Services who did have information that she was waiting for an

	appointment or with the Youth Offending Team. Tameside Youth Offending Team did not have access to Tameside Children's Social Care records so did not realise that Kesia had been referred to them.
6.	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 11th June 2015. 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 namely, namely to the family of Kesia. 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.	**Date: 16th April 2015** **Miss Joanne Kearsley** **H M Area Coroner** **Manchester South**