	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Ms Mary Harpley, Chief Executive, Hounslow Borough Council, Hounslow Civic Centre, Lampton Road, London TW3 4DN**
1	**CORONER** I am Penelope Schofield, Senior Coroner, for the area of West Sussex, sitting as Assistant Coroner for East Sussex.
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 1st June 2016 I, together with a Jury, concluded the inquest into the death of Amy Rose El-Keria born 14th May 1998 (aged 14 yrs), who died on 13th November 2012. The Jury determined that Amy had died from the complications arising from Hypoxic Ischaemic Brain damage following the tying of a ligature around her neck. The Jury return a narrative questionnaire in which they found that Amy's death had been contributed to by Neglect and they also found that there were a number of causative failures which led to her death. A copy of the narrative questionnaire is attached.
4	**CIRCUMSTANCES OF THE DEATH** Amy El Keria was aged 14 years old at the material time. She had a range of complex needs associated with a number of mental health diagnoses. Up until the time of her hospital admission she lived with her mother and sister in Hounslow. Following her exclusion from school in early 2012 her mental health deteriorated and she started to ligature. In August 2012 she was seen for an emergency outpatient assessment and a planned inpatient admission was sought. However there were no specialist Child and Adolescent high dependency beds available immediately and Amy had to be admitted to the Priory Hospital at Roehampton. The following day she transferred to the Ticehurst House Hospital which is part of the Priory Group. During her stay at Ticehurst Amy's mental health fluctuated and at times she had to be forcefully restrained and sedated On 12th November 2012, having told staff earlier in the day that she wanted to kill herself, she tied a ligature, namely a football scarf, around her neck and suspended herself from a radiator in her room. She subsequently died from her injuries the following day.
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:- (1) The evidence given at the Inquest showed that there was a clear misapprehension by Hounslow Social Services as to their role in supporting Amy whilst at Ticehurst. It appears that Social services did not appreciate their important ongoing role to ensure Amy's welfare whilst placed at Ticehurst. [redacted] the Court expert, gave evidence that Hounslow may have seen this health

	funded placement as a stand-alone intervention that did not require their input. (2) Social Services clearly have a vital role to play in ensuring family contact where a child is placed far from their family home where difficulties arise. There was no assessment carried out to assess whether there was any need to provide support to a child in need under Section 17 Children Act 1989 even when Amy's mother had specifically raised the difficulties she was having with contact with Amy , including the cost of travel, with her support worker. (3) The family gave evidence to the extent that having better contact with Amy and more input into her care may have brought about a different outcome particularly when she was distressed. I consider that the issues raised in this case should be addressed so that future deaths do not occur in similar circumstances and that action should be taken to reduce the risk of deaths of other children.
	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 by addressing these issues.
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 November 2016. 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: 1. [redacted] 2. The Priory Group 3. [redacted] 4. [redacted] 5. West London Mental Health Trust 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.
	DATE: 3rd October 2016 **SIGNED: Penelope Schofield, Senior Coroner, West Sussex sitting as Assistant Coroner, East Sussex**