Tony Williams
Senior Coroner for Somerset

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Head of Services** **CAMHS West, Foundation House, Wellsprings Road, Taunton, Somerset. TA2 7PQ** **The Managing Director, NHS Somerset Clinical Commissioning Group, Wynford House, Lufton Way, Lufton, Yeovil, Somerset. BA22 8HR** **Director of Children's Services, Somerset County Council, County Hall, Taunton, Somerset. TA1 4DY**
1	**CORONER** I am Tony Williams, Senior Coroner for the Coroner Area of Somerset
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 22/09/2016 I commenced an investigation into the death of Sofia Ann Legg. Sofia was aged 14 years when she died on 26th September 2016. The medical cause of death was hanging. The conclusion of the inquest was suicide, that on 20th September 2016 at 25 Saxon Way, Cheddar, Sofia deliberately suspended herself by the neck with the intention of ending her life.
4	**CIRCUMSTANCES OF THE DEATH** Sofia had previously suffered from low mood. In Year 8 both school and family noticed significant changes in Sofia's behaviour, including self-harming. Sofia's mother was sufficiently concerned to attend the family G.P. who wrote to CAMHS West supporting a referral from Sofia's school. By letter dated 2nd April 2015 CAMHS West stated that Sofia's difficulties did not meet criteria for specialist CAMHS intervention. In February 2016 Sofia attended her G.P. with her mother, Sofia's hair was starting to break, her self-confidence fell as her hair became thinner. Sofia and her mother returned to the G.P. a number of times and in June 2016 the G.P. agreed if Sofia was stressed, it was documented that Sofia has been low for months, was self-harming again but denied any suicidal thoughts. Following an attendance at the G.P. on 12th July 2016 it was noted that Sofia has expressed some suicidal thoughts. An expert referral was made to CAMHS West. Sofia was seen by a care-co-ordinator at CAMHS West on 15th July 2016 and again on 29th July 2016. Sofia was given the opportunity to speak to the care coordinator alone. Sofia was placed on a 6 month waiting list for CBT. Sofia appeared to her mother to have a good summer holiday but upon returning to school in September 2016 Sofia started to isolate herself. Sofia's mother arranged an appointment with Sofia's care coordinator at CAMHS on 19th September 2016. Again Sofia had the chance to speak to the care co-ordinator alone and again Sofia admitted to suicidal thoughts. From the evidence of the care co-ordinator and Sofia's mother it was identified that there was a difference in recollection of what was discussed and expressed at that meeting. Matters that the care coordinator identified as discussed were not subsequently identified in Sofia's care plan, the care co-ordinator has no urgent contact with Sofia's school and no urgent contact with a psychiatrist. No follow up appointment was made. On the following day 26th

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	September 2016 Sofia's mother following discussions with Sofia attended work and upon return home discovered Sofia hanging. Sofia left an apologetic 'suicide note'.
5	**CORONER'S CONCERNS** 1. Access to CAMHS. Sofia was rejected for referral in April 2015. Might a lower threshold and earlier proactive interventionist policy has been of positive benefits to Sofia. 2. Availability of CBT. Sofia was placed on a 6 month waiting list for CBT. This delay appears considerable. 3. Sofia's care co-ordinator at CAMHS did not obtain the urgent input of a psychiatrist in accordance with NICE guidance. 4. The recollections of Sofia's care co-ordinator and Sofia's mother as to the meeting of the 19th September were at odds with each other. Sofia's care co-ordinator recollected in her evidence telling Sofia's mother that Sofia was not to be left alone. Sofia's mother deemed the impression from Sofia's care co-ordinator's evidence was of Sofia being an extremely vulnerable and dangerous position abut this was not reflected in Sofia's care plan which made no mention of her not being left alone and it was not reflected in the care co-ordinator's actions in not urgently contacting Sofia's school, where she would be during the following days to a psychiatrist. Her care plan appears to be the critical written record of the outcomes of this meeting as it was not of sufficient detail to safeguard Sofia. 5. Language used in the SIRI Report was felt to be inappropriate. The SIRI Report effectively said if the care plan had been followed the outcome might have been different and that no change in clinical practice would have resulted in any different outcome. I do not believe either of these statements were true.

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 29th November 2017. 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] [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. 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	Dated 04 October 2017 Signature [redacted] Senior Coroner for Somerset

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