	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **Amanda Spielman** **Chief Executive** **Ofsted** **Piccadilly Gate** **Store Street** **Manchester** **M1 2WD**
1	**CORONER** I am Penelope Schofield, Senior Coroner, for the area of West 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 5th July 2017 I concluded the inquest into the death of Steffan Bonnot born 6th November 1988 (aged 17) who died on 1st January 2016. His Inquest was originally opened on 12th January 2016. The Conclusion that I reached at the Inquest was that Steffan committed Suicide. At the time of his death he was in the care of Brighton and Hove Local Authority.
4	**CIRCUMSTANCES OF THE DEATH** Steffan was a young man who has had spent a considerable amount of time in foster care and children's homes. He was due to move out of the Amicus Community Children's home and into another foster placement on 16th January 2016. It was clear from the evidence that he was concerned about leaving the Amicus Community and that he was anxious about whether or not the Foster Carers were fully appraised of his background. He had had a large number of Foster placements in the past many of which had broken down. The concerns he had about how much the Foster Carers knew caused him some anxiety. On Friday 1st January 2016 Steffan was amongst a small group of children who attended the local cinema. This was a pre-arranged outing. On the return from the cinema Steffan's group, which consisted of two staff and another child, stopped off at MacDonalds. Shortly after arriving at MacDonalds Steffan and the other young man went to the Toilet. A member of staff followed them shortly afterwards and asked them to come out. Steffan did so but then left MacDonalds without saying anything. The staff tried to follow him and locate him. They were unable to do so and sadly Steffan body was later found at the Warningcamp footcrossing having been struck by a train. Steffan had deliberately knelt down in front of an oncoming train
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 author of the serious case review reported that the prospective foster carers who were to offer a placement to Steffan had advised that they had not been made fully aware of all the background to Steffan's case. This was, however, at odds with what Steffan's Social worker told us. However there was no formal documentation detailing exactly what had been disclosed. It was not therefore possible to be clear what information the prospective Foster Carer had been given. As we know the failing to provide Foster Carers with all the background information was one of Steffan's major concerns and added to his level of anxiety about his move.
2. The above concern would apply equally to any individuals entrusted with the care of a child. All relevant information should be made available and it should be documented as to what has been provided so that the carers can make an informed decision before any placement is agreed. The young person could then be confident as to what the prospective carer's knew.

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 patients.

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 12th September 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**

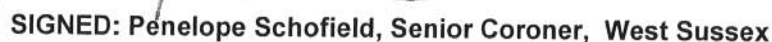
I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

1.
2. Brighton and Hove Children's Services
3. - Author of the Serious Case Review

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: 14th July 2017



SIGNED: Penelope Schofield, Senior Coroner, West Sussex