	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: 1. Cumbria Partnership NHS Foundation Trust (the Trust). 2. North Cumbria Clinical Commissioning Group. 3. Morecambe Bay Clinical Commissioning Group. 4. Secretary of State for Health and Social Care.**
1	**CORONER** I am Mr David Llewelyn Roberts Senior Coroner for **County of Cumbria**
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://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 12th April 2017 I commenced an investigation into the death of Karen Jane Edgar. The investigation concluded at the end of the inquest on 13th April 2018. The conclusion of the inquest was Karen was suffering from emotional and behavioural issues and was referred to Child and Adolescent Mental Health Services (CAMHS) in October 2015, aged 15. Her first substantive meeting with her mental health practitioner was on 8th February, 2016, when family work was planned. She did not start individual talking therapy until 7thApril. Family therapy had ceased to be available. After only one more 1:1 session on 25th April she was, on 5th May, seen by a psychiatrist who prescribed fluoxetine-10mg. In July it was increased to 20mg. On 29th September she took an overdose of paracetamol, then raised the alarm and received inpatient general hospital attention. Her true intention was not clear. The psychiatrist changed her medication to sertraline 50mg which commenced on about 7th March 2017, after only twelve 1:1 sessions. On 22nd March she was involved in an outburst at school relating to her boyfriend, from whom she had split in February. At the 1:1 on 29th March she was angry and upset and later that day researched 'suicide note' on the internet. Sertraline was increased to 100mg on 30th March. She had convinced herself she was pregnant and told her former boyfriend on 1st April. She admitted to a friend having tried to hang herself. On the evening of 7th April she had an angry exchange with her former boyfriend over the pregnancy issue via text and went home. Whist her parents were not in the house she hanging herself from a dressing gown cord in a wardrobe in her bedroom. She was discovered soon afterwards, but despite medical treatment did not recover and was pronounced dead at West Cumberland Hospital at 01.10 hours on 8th April. She had made a cut in the ligature with a pair of scissors. Medical cause: Hanging. Conclusion: Misadventure; she hanged herself as a gesture intending to be discovered.
4	**CIRCUMSTANCES OF THE DEATH** Karen had been displaying behavioural and anger problems for many months when there was a major incident in August 2015 which resulted in her and her parents seeking help. Despite a referral to CAMHS in October 2015 assessment appointments did not take place until early December and January. Family work was proposed but only two meetings took place before it ceased to be available. Karen did not start 1:1 work until April 2016, nearly six months from first seeing her GP. She only had 13 talking sessions from the first assessment in December 2015 until her death in April 2017. The psychiatrist diagnosed her with moderately severe depressive disorder and prescribed antidepressants after only two 1:1 sessions. (NICE suggests 4-6 sessions). She was not monitored closely on four drug changes. It remains an open question as to whether the introduction of sertraline a month before is implicated in her death. Whilst the mental health worker did her level best it seems that the resources were inadequate to support Karen and she received sub-optimal care. The Trust's own report revealed a long list of failings including:- no care plan; lack of 'packages of care'; gaps in work force and skills base; absence of family therapy; failure to re-assess risk formally; lack of Multi-disciplinary Meetings; absence of holistic approach and not engaging more productively with her school. Many of these issues were themes found to be endemic in the Trust by the CQC in its report of 26th January 2018.

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 provision of mental health services for children and young people in Cumbria is underfunded. (2) There are long delays in getting treatment. (3) Failure to provide for these young people means they risk entering adulthood with unresolved mental health issues. (4) Lives are lost and damaged; including the effect on families as a whole. (5) The financial cost to the state of such deaths is huge; 4 paramedics attended as did an out of hours doctor; at least 11 police staff; hospital staff; A&E consultant; Local Safeguarding processes; costs of inquests and Trust's legal representation etc. all of which would be better spent on prevention. (6) It is likely that any of these problems are replicated across the country hence the reference to the Secretary for State.

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 12th June 2018. 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 [redacted] and to the CUMBRIA LOCAL SAFEGUARDING BOARD (as the deceased was under 18.. I have also sent it to [redacted], CQC, Self Harm Awareness for All Cumbria (Charity), Office of the Children's Commissioner, Head Master Workington Academy, the Press. who may find it useful or of interest. 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	16/04/2018 David Roberts Mr David Llewelyn Roberts Senior Coroner **County of Cumbria**