	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **South London & Maudsley NHS Foundation Trust (SLAM)** 2. **[redacted] and Steel & Shamash Solicitors** 3. **Southwark Safeguarding Children Board** 4. **The Chief Coroner**
1	**CORONER** I am the assistant coroner for the coroner area of Inner London South
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 11/10/2017 an investigation was opened into the death of Katy Roberts aged 16. The investigation concluded at the end of the inquest on 12/04/2018. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** Several years before her death, Katy was diagnosed with Asperger's Syndrome, PTSD with a history of Anxiety, Depression and an eating disorder and was under the care of the Child and Adolescent Mental Health Service (CAMHS) at SLAM at the time of her death. In around May 2017, the care plan that had been formulated and notified to Katy in writing was significantly altered. Although this change was communicated orally to Katy and her family, it was not confirmed in writing and little, if any opportunity was provided to appeal this decision to alter Katy's care plan, despite the family's increasing concerns over its appropriateness for Katy. Consequently, at the time of her death Katy was under a care plan believed by the family to be unsuitable for her, thereby exacerbating a breakdown of trust on the part of Katy's family in the service provided by CAMHS/SLAM and creating a lack of provision for care or advice when a crisis, due to unexpected circumstances arose.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern, although many of these were addressed in an investigative report prepared by SLAM. However, in my opinion a continued failure to clearly communicate changes to a care plan and provide a clear route to challenging or appealing these changes, together with the provision of details of all avenues for seeking emergency and non-emergency care and advice, create 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) Failure to communicate in writing a Care Plan and changes to it. (2) Failure to provide a clear route or opportunity to challenge or appeal these changes

	to the Care Plan. (3) Failure to expressly communicate in writing all routes by which, to raise concerns and seek help on a non-emergency or emergency basis.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 22/06/2018 although 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 and [redacted] and to Southwark Children Safeguarding Board as Katy was under 18 at the time of her death. 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	**27/04/2018** **SIGNED BY CORONER: LM Tagliavini**

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