for Plymouth Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Secretary of State for Education, Secretary of State for Health
1	**CORONER** I M ARROW, Senior Coroner, Plymouth, Torbay and South Devon
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** Inquest detail Following an investigation commenced on the 8th day of January 2018 and Inquest opened on the 8th day of January 2018: At an inquest hearing at Coroner's Court Derriford Park Plymouth on the 30th day of July 2019 heard before IAN MICHAEL ARROW Senior Coroner in the coroner's area for Plymouth, Torbay and South Devon, the following findings and determinations were made: **Name:** Daniel Cameron SHORROCKS **Medical Cause of Death:** Multiple Injuries **Conclusion:** Took own life On 1 January 2018 at Berry Head, Torbay, Devon
4	**CIRCUMSTANCES OF THE DEATH** The deceased was born in Torbay on 3 September 2000. Before his birth Torbay Childrens Social Care had identified potential for his significant harm following his birth. He was known to the Police by September 2002 when he was found playing alone in a park. Reports were made to Torbay Childrens Social Care indicating that he had been neglected. At age five, consideration was given to long term care by Torbay Childrens Services. In June 2007 approval was given for a kinship care in Essex. This was brought to an end at short notice and he was returned to Torbay. He spent several years in various foster care and respite care placements. The precise number of placements could not be identified. In January 2010 he was made know to the Child Adolescent Mental Health Service following his jumping a river and expressing a wish to die. On 18 September 2017 the deceased's then foster carer became concerned for his welfare, having found a note. The Police were notified. The

	deceased was located on a viaduct by the Police and taken to a place safety for assessment. He was referred to the Child Adolescent Mental Health Service Crisis Team. The Crisis Team subsequently closed his support/case. On 14 December 2017 he was accepted into the Torbay Autism Assessment Service. On 1 January 2018 the deceased told his then foster carer that he was going to visit a friend and would return at 7pm. The deceased visited his friend. The account of the investigating Police Officer is that he discussed ending his own life with the friend. At 7.01pm his foster carer received a text 'Dead at Berry Head'. The deceased's jacket was located at the top of a cliff at Berry Head. His dead body was at the foot of the cliff.
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) I ask please that your Department reviews the availability of resources to those Local Authorities which have a high proportion of young people in care and disproportionately few qualified and experienced staff. (2) I would also ask your Department to review the integration of services between Local Authority Care Services, Adolescent Mental Health Services and Pastoral Care provided in education settings.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as Secretary of State 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 26 September 2019. 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: Director of Childrens Services, Torbay Council; Chief Executive; Childrens Commissioner; Children Adolescent Mental Health Service / Devon Partnership Trust; the deceased's mother, for information; Mr Foster MP; Dr Woolaston MP; 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 1 August 2019 Signature