Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 **Chief Operating Officer, NHS Milton Keynes Clinical Commissioning Group**
2 **Chief Executive, Public Health England**

1 CORONER

I am Elizabeth GRAY, for the area of Milton Keynes

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 13/11/2018 I commenced an investigation into the death of aged Sam Michael Carl Grant aged 16.

The investigation concluded at the end of the inquest on 28/06/2019. The medical cause of death was:

1a Hanging from ligature around the neck

4 CIRCUMSTANCES OF THE DEATH

Sam died on 09/11/2018 at home [redacted] Milton Keynes having been found hanging by the neck by his sister on her return from school. Sam had been engaged with COMPASS services through a school referral. He had been referred to CAMHS in May 2018 but did not meet the threshold for engagement. His GP suggested other organisations who Sam could approach voluntarily for support, but he did not take up these suggestions.

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) Sam's GP referred Sam to CAMHS when he presented to the GP with irritability, anger and a report that he was close to being excluded from school. CAMHS rejected the referral because Sam did not meet their threshold of moderate to severe mental health issues. CAMHS did not suggest any alternative assistance. The GP did follow up with Sam to sign post him to two independent organisations who Sam would have to approach independently for help. The GP made it clear in his evidence that there is a lack of lower level assistance for young people who present with 'life issues' such as low mood, irritability and anger issues, but who nonetheless need help and assistance but do not meet the criteria for access to CAMHS services.

2) Sam had been referred to, and was receiving the services of COMPASS having been referred by his School. The GP was not made aware of this engagement and was unable to take this into

account at the time when Sam did present himself to the GP. The evidence from COMPASS is that they maintain the confidentiality of patients even minors using their services unless they have express consent to disclose that information from the patient themselves. Without all relevant information neither the GP nor CAMHS was in a position to make a fully informed decision about the Sam's needs. Sharing of information between relevant health agencies to ensure fully informed decisions are made as regards the healthcare needs of an individual should be a priority.

3) Evidence at the inquest from the GP also indicated that a reduction in healthcare provision at Sam's school and in particular the removal of a medically qualified person(s) has meant that confidential health information is no longer shared between the school and the GP surgery. The school now only engages First Aiders, who are not medically qualified, and who do not therefore exchange information which in the past has proved essential in flagging concerns between the GP and the School. This is another route which has been closed and which would have allowed a potential flag to have been raised in respect of concerns around Sam and his wellbeing to be shared confidentially between GP and school.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 20th September 2019. I, the Assistant 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:
The family of Sam Grant
Central Northwest London NHS Foundation Trust

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.

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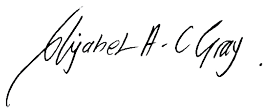

Elizabeth GRAY
for
Milton Keynes
Dated: 26 July 2019