REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health, Secretary of State for Education, Chief Executive of Stockport Clinical Commissioning Group (CCG), Greater Manchester Health & Social Care Partnership
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester 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 18th October 2018 I commenced an investigation into the death of Oliver Sharp. The investigation concluded on the 20th September 2019 and the conclusion was one of: **Narrative: Suicide contributed to by a failure by mental health services to recognise the increasing level of risk he presented as he transitioned from child and adolescent mental health services into the reduced provision and support available post 16.** The medical cause of death was **1a) Heroin Overdose**
4	CIRCUMSTANCES OF THE DEATH Oliver Richard Sharp was a year ahead of his chronological age at school and excelled academically. Whilst at Manchester Grammar School he began to change his approach to school and his friends. He disclosed to a CBT therapist the extent of how he was struggling with how he felt about himself and his friendships. On 17th April 2016 he disclosed he was self-harming. On 21st April 2016 he saw the GP and was referred to CAMHS. On 25th April 2016 Oliver took 48 Paracetamol tablets

and disclosed that to his family who took him to Stepping Hill Hospital. He returned to school and continued under CAMHS. He was put on a 6 month waiting list for an ADOS assessment, which took place in November 2016 and was inconclusive.

In September 2016 he returned to year 11 at Manchester Grammar School. He was struggling to cope with the academic demands and there was a focus on trying to help him catch up academically and keep him safe. He showed signs of becoming concerned about failing and struggled to cope with friendship groups. The delayed ADOS assessment indicated he was not autistic.

He continued to self-harm over Christmas 2016, and on 2nd January 2017 he took an overdose of paracetamol and was admitted to Stepping Hill Hospital. It was agreed with CAMHS that a 2nd opinion would be sought about him. The psychiatric assessment identified a complex picture including difficulties with emotional literacy and empathy. The overall diagnosis was of Autistic Spectrum Disorder (ASD), ADHD and Emotional Behavioural Dysregulation.

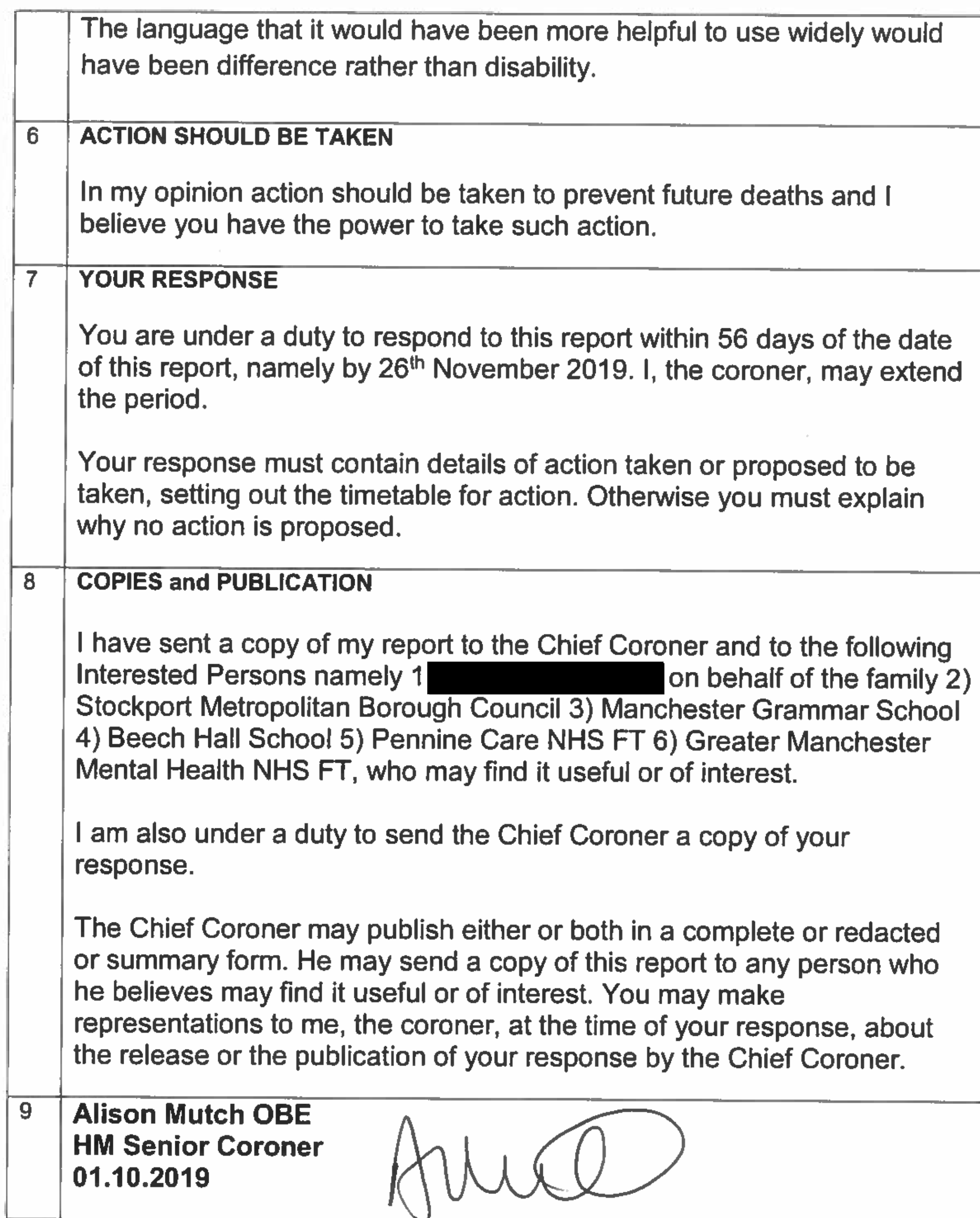
Following his January overdose, work continued with CAMHS and he returned to school. He became increasingly isolated and by the time of GCSEs he took only English and Maths but did not answer the papers. He left Manchester Grammar School and transferred to Beech Hall School in September 2017, dropping back to a year below his chronological age to repeat year 10. Over summer 2017 he began to work with the Autism Team and they helped support him into Beech Hall School.

In October 2017 he went missing from home and was found on a motorway bridge at 5am. He had not been taking his medication. Family therapy and sessions with his case manager continued. There were discussions about post 16 provision as he approached his 16th Birthday. CAMHS within Stockport is a service for children up to 16. Discussions regarding discharge continued and because of the way in which Mental Health Services were structured the plan was to discharge to the GP. Overall he had settled at Beech Hall, although attendance was erratic. In June 2018 the last family therapy session was due to take place. He had gone missing from home.

On 12th June 2018 he presented at Manchester Royal Infirmary seeking help having slept rough in Manchester and reporting thoughts of suicide. He was discharged to CAMHS for follow up. On 14th June 2018 he told Beech Hall he was likely to harm

himself if he went home. They took him to Macclesfield A&E where a detailed assessment and gathering of information resulted in him being admitted on a voluntary basis to the Hope unit.
He arrived there at 1am on 15th June. He did not like it. He was assessed and was allowed to leave the unit on 15th June. Following further psychiatric assessment from the unit whilst in the community he was placed on quetiapine. Concordance was initially good but deteriorated. The planned discharge from the Hope Unit services took place on 2nd July 2018. On 2nd July 2018 he went missing from home and was found at Crewe Railway Station. The CAMHS plan was to discharge him and move him to the transition team which was discussed on 20th August 2018. He was to have a new therapist.
On 24th August 2018 he went missing from home. He was found and taken to Stepping Hill Hospital and assessed by RAID. He had bought paracetamol with the intention of taking his life. He expressed concern about his discharge from CAMHS. He was discharged to see CAHMS on 31st August 2018. He was due to return to Beech Hall on 5th September 2018.
On 5th September he was reported as missing from home. He was found by a member of the public in the early hours of the morning having taken an overdose of heroin. Medical intervention reversed the outcome of the overdose. He was assessed by the RAID team. There was a failure to consider the full circumstances of his history and a failure by mental health providers involved in his care to effectively communicate. As a result the level of risk he presented was not adequately understood. He was discharged to the Home Treatment Team. The Home Treatment Team saw him on 13th September 2018. Professionals in his care recognised the increasing risk in relation to his behaviour. The Home Treatment Team failed to appreciate the level of risk he presented.
On the evening of 14th September 2018 he presented at A&E at Stepping Hill Hospital with suicidal ideation. He was seen and assessed by RAID. There was a failure to fully assess him or understand the complexities and level of risk he presented. He was discharged home into the community to see the Home Treatment Team on 15th September 2018. He saw the Home Treatment Team on 15th, 18th and 30th September 2018. On 30th September he was discharged from the Home Treatment Team.
On 8th October at school he appeared to accept the reduced academic aspirations for him. A further reduced academic

	timetable was sent to him on 12th October 2018. On 17th October 2018 he went missing from home. This was reported to Greater Manchester Police. On the morning of 18th October 2018 he was found by a dog walker in Gatley Hill. A typed note was found on him. He was taken to Wythenshawe Hospital and his death was confirmed. Toxicology confirmed that he had taken a fatal dose of heroin.
5	<u>CORONER'S CONCERNS</u> 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. – The inquest was told that the provision of mental health services post 16 varies widely across the country. In some areas there is a CAMHS 16-25 mental health service provision similar to the national 16 and under service whereas in other areas there a limited transition service or move back to primary care for re-referral to adult services. The inquest was told that this creates a cliff edge high risk situation for adolescents. The reason for the difference was resources and decisions taken by CCGs. The inquest was told that it is important for autism to be diagnosed as early as possible so that appropriate support can be put in place. Early diagnosis was impacted by a national picture of long waiting lists for ADOS assessments. In Stockport there was approximately a 6 month waiting list for assessment. This was against a national picture of 12-24 month waits in some areas. During the inquest evidence was heard that acceleration ahead of a chronological school age might cause relatively few difficulties in peer relationships up to about year 9 but post that as children entered adolescence it could become a significant issue impacting a child's mental health and ability to cope. Where it did happen, there needed to be an understanding by schools of the risks and early signs indicating a need for additional support to try to reduce the likelihood of self-harming behaviours and the potential need for additional support. The inquest heard that Oliver had found the autism label and the label of disability that was attached to it very difficult to accept as time went on. There was evidence that particularly with high achieving children with autism the idea that they had a disability created additional challenge.



	The language that it would have been more helpful to use widely would have been difference rather than disability.
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 26th November 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 namely 1 [redacted] on behalf of the family 2) Stockport Metropolitan Borough Council 3) Manchester Grammar School 4) Beech Hall School 5) Pennine Care NHS FT 6) Greater Manchester Mental Health NHS FT, 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	**Alison Mutch OBE** **HM Senior Coroner** **01.10.2019**