Derby & Derbyshire Coroner's Area

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Rt Hon Gavin Williamson CBE MP, Secretary of State for Education, Department for Education**
1	**CORONER** I am Peter Nieto, Area Coroner, for the Coroner Area of Derby & Derbyshire.
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 17 July 2017 I commenced an investigation into the death of Jacob Andrew Bates (dob: 5 January 2000; dod: 15 July 2017). The investigation concluded by way of an inquest hearing from 2 to 5 December 2019 (a copy of the record of inquest is enclosed with the covering letter to this report). My findings at inquest were as follows: - - Medical cause of death: - 1a Ligature around the neck. 1b Mental health issues and autism. - Summary of circumstances: - Jacob died as a result of placing plastic ties around his neck as ligatures. Although he had not given any immediate indication to anyone that he was contemplating taking his own life he was assessed as being at on-going risk of serious self-harm. Due to the nature of the act, his self-harm history, the on-going assessed risk, and his leaving of a 'suicide' note I found that he had undertaken a deliberate act with the intention of taking his own life. Just prior to his death a six month unregulated placement had recently been ended, and prior to that placement he had spent over two and a half years in a succession of secure placements.

	On the evidence I did not find that factors associated with the unregulated placement had directly contributed to Jacob's death. - My conclusion as to Jacob's death was a short form conclusion of *suicide*.
4	**CIRCUMSTANCES OF THE DEATH** Jacob had diagnoses of autism and mental health problems. Following a serious overdose in February 2014 he was thereafter placed in a succession of secure placements under the provisions of the Mental Health Act 1983 and the Children Act 1989 until he returned to his home area of Chesterfield around Christmas 2016 when he was placed, under the provisions of s.20 Children Act 1989, in an unregulated placement for young people aged between 16 and 18 years of age and was also supported by local authority social care and child and adolescent mental health services. The Chesterfield placement was not a specialist placement for young people with autism or mental health problems and the placement had been made in the context of a specialist placement having given very short notice of termination of placement. There had been many episodes of self-harm following the overdose in February, some serious, including just two months prior to his death and he was assessed at on-going risk of serious self-harm. The Chesterfield placement came to an end following Jacob's decision to move in to live with his father where he received on-going support from the agencies.
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. As I have stated I did not find that the evidence established a causal or contributory connection between the unregulated placement and Jacob's death. I found this to be so on the applicable civil law test, the balance of probabilities. However in my summing-up I did express my serious concerns that Jacob had been placed in an unregulated placement despite his history, needs, and risks. Evidence was given at the inquest hearing by two former employees at the placement that they had no prior experience of working with young people (indeed no experience of working in any form of care-related work) and were left in charge of the unit where Jacob was placed after a very short period of commencing employment (one former staff member said that he had only completed two shadowing sessions before being asked to be in sole charge of the unit overnight). The evidence of the responsible local authority was that it had not sought evidence from the placement provider as to staff competency and training, or that suitable policies and procedures were in place; it effectively accepted the assurances of the provider.

	The local authority stated that it now has systems providing for greater scrutiny and diligence but it was explained that where residential/supported provision is solely for young people aged 16 to 18 that provision falls outside or the statutory regime of inspection and regulatory compliance as enforced by Ofsted. My understanding is that the issue of unregulated placements for 16 to 18 year olds has been widely highlighted as a cause for concern but the evidence of a senior local authority manager at inquest was that she was unaware of any plans nationally to address the issue despite concerns having been very widely raised. The **MATTERS OF CONCERN** are as follows: - 1. Vulnerable young people, aged 16 to 18, are being placed in unregulated placements. 2. Any young person under the age of 18 placed in an unregulated placement is likely to have very significant vulnerabilities, and it is likely that young people with complex needs and at significant risk are being placed in such placements; indeed this was the case for Jacob. 3. As the placements are unregulated there are no statutory regulations to comply with relating to competency and appropriate policies and procedures by the provider and there is no regulatory body to check and assess those providers. This is clearly a very concerning situation given the very high level needs that some of the young people will have. 4. The lack of statutory regulation then places an onus on local authorities to check that a provider is competent and safe. Whilst in making individual placements it must be the duty of a local authority to satisfy itself as best as it is able that placements are 'safe', given the pressures on local authorities it cannot be the case that they are in a position to mirror the type and nature of inspection and oversight that might be provided by a regulator such as Ofsted. 5. In view of the points made above the lack of statutory regulation is placing vulnerable young people at risk, and there is a realistic possibility that deaths may occur.
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 **27 February 2020**. 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 : 1. Susan Cheetham (Jacob's mother). 2. Glen Billyeald (Jacob's father). 3. Derbyshire County Council. 4. Derby and Derbyshire Clinical Commissioning Group. 5. Emma House. 6. Barnardos 7. Derbyshire Constabulary. 8. Chesterfield Royal Hospital 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.
9	**31 December 2019** **Mr Peter Nieto** **HM Area Coroner** **Derby & Derbyshire Coroner's Area**