REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive, Denbighshire County Council, County Hall, Wynnstay Road, Ruthin LL15 1YN
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and Central)]
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 the 16th of August 2011 I commenced an investigation into the death of Laura Beth Newlands (DOB 3.11.1995 DOD 12.8.2011). The investigation concluded at the end of the inquest on the 27th of November 2015 and I recorded a conclusion of Suicide with the cause of death being 1(a) Trazodone Overdose
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are that the Deceased had been known to Denbighshire Social Services (DSS) as a result of referrals from her school and the Child and Adolescent Service (CAMHS) due to concerns relating to her self harming as a result of difficult home circumstances. Although action was initially taken by DSS, her case was then closed and thereafter there was a delay in taking further action to provide support to her as a Professionals' Meeting was not arranged in a timely fashion and she took her own life by way of an overdose four days before the scheduled meeting.
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. Although a "safety plan" is prepared by CAMHS at the time of discharge from

	hospital, there does not appear to be sufficient input to this document by DSS with the result that those caring for a young person at risk may have incomplete written information available to them to properly ensure the safety of the young person. 2. A delay in scheduling an appropriate meeting of Professionals resulted in a missed opportunity to provide support and protection of a young person at risk and there was not therefore a prompt response to a crisis 3. The decision to close the case (and then not to reopen the same) by DSS resulted in there being no further assessments conducted at a time when action should have been taken and could have resulted in additional support for the deceased and her family. Such a decision may not have been made if the case had been reviewed by a senior staff member who was not directly involved in the investigation.
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 27th January 2016 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 Person - [redacted] (parents of the Deceased) [redacted] Uncle of the Deceased) 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	**[DATE] 2nd December 2015 [SIGNED BY CORONER]**