REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Chief Executive Officer, BURY COUNCIL
1	**CORONER** I am Edward Morgan, Assistant Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 29 August 2018 the Senior Coroner commenced an investigation into the death of **Shneur Zalman Kaye.** The Inquest concluded on 17 January 2020 when I recorded a conclusion of Misadventure.
4	**CIRCUMSTANCES OF DEATH** Shneur died at home on 24 August 2018, by reason of suffocation caused by inhalation of helium. He was 14 years old. For some years, Shneur had experienced behavioural difficulties. He had been diagnosed with ADHD and had been supported by the community paediatric team. His treatment included regular medication. On 17 April 2017, Shneur was conveyed to North Manchester General Hospital following erratic behaviour and a suggestion of an overdose. North West Ambulance service filed a Safeguarding Referral with the Multi Agency Safeguarding Hub (MASH) operated by Bury on 17 April 2017. At that time, Shneur was not attending any local authority maintained school. He was not previously known to Social Services. On 19 April 2017, the social worker decided there was no need for action and the referral was closed. Prior to closure of the referral, there was no contact made with the family or with Shneur himself. Following this decision, neither the fact of the referral or the reasons for it was shared with any third party, service or agency.
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. The decision to close a referral without prior contact with parents (where there is no safeguarding or legal reason why such contact should not be made) potentially deprives the Social Worker of the opportunity to contextualise the event or concern which has triggered the referral, and of forming an informed view of the welfare of the child to whom the referral relates; 2...The evidence received by the Court indicates that the closure of the safeguarding referral marks an end to social services involvement. Despite this no attempt is made to share the fact of the

	referral or the reasons for it with any third party, service or agency. This may have the unintended result of depriving third parties (including parents) and agencies already participating in the care and welfare of a child from being alerted to the concern and taking appropriate action (including accessing other services) in response to it. The submissions made on behalf of the council indicate these practices are driven by considerations of data protection compliance The practice imperils the precedence to be given to the paramountcy principle and has the potential to undermine the protection of children who are the subject of referral.
	ACTION SHOULD BE TAKEN **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 13/3/20, 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] 2. [redacted]OYY Lubavitch School, 4 upper Park Road, Salford 3. Pennine Acute NHS Trust; 4. Pennine Care NHS Foundation Trust 5. [redacted] Longfield Medical Practice, Prestwich, Manchester 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 from. He may send a copy of this report to any person who he believes may find it usefulor 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: Signed: 17 January 2020