REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Cambridgeshire and Peterborough Foundation Trust (CPFT)** **(2) Cambridgeshire County Council (CCC)**
1	**CORONER** I am NICHOLAS MOSS QC, assistant coroner for the coroner area of CAMBRIDGESHIRE AND PETERBOROUGH.
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. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5 https://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** An investigation commenced on 13 September 2018 into the death of **SAMANTHA JANE GOULD (Sam) aged 16**. The investigation concluded at the end of the inquest on **16 April 2021**. An investigation commenced on 5 February 2019 into the death of **Christine Elizabeth GOULD (Chris) aged 17.** The investigation concluded at the end of the inquest on **26 May 2021**. These were separate inquests. • Sam died by suicide by an overdose of prescribed medication on 2 September 2018. • Chris died by suicide when she deliberately stepped in front of a passing train on 26 January 2019. The conclusion in relation to Sam's death was that the main cause of her death was her Borderline Personality Disorder, which treating clinicians assessed to be related to allegations of prolonged sexual abuse in her earlier childhood. The conclusion in relation to Chris' death was that the main cause of her death was: (1) her serious mental health disorder (variously diagnosed as Borderline Personality Disorder, Complex Post Traumatic Stress Disorder and Mixed Disorder of Conduct and Emotions). Treating clinicians assessed this to be related to allegations of prolonged sexual abuse in her earlier childhood; (2) The recent death by suicide of her sister Sam (who also suffered from Borderline Personality Disorder) similarly assessed by clinicians to be related to the allegations of their prolonged sexual abuse. In each case, there was a wider narrative conclusion and factual findings delivered in Open Court. Relevant to both CCC's and CPFT's involvement in Sam's death the narrative conclusion included that: "*Following two very challenging school related incidents in February 2018, Sam's secondary school faced a difficult decision on whether to permit her to be educated on the main school site. Their decision making approach was unsatisfactory,*

	although they were entitled to be very concerned at the risks involved in Sam being taught on the main site. Communication and joint working between the school, the local authority and CAMHS was, in significant respects, ineffective. A degree of distress and disruption from the events in February 2018 was inevitable but the agencies did not sufficiently mitigate their impact." Relevant to CCC's involvement in Sam's death, I detailed shortcomings in my factual findings regarding how both education and social care sides of the local authority dealt with Sam's needs. Relevant to CPFT's involvement in Chris' death, the narrative conclusion included that: *"When a patient went missing, there was provision for CPFT to contact the train signallers direct in order to slow the local trains (this was provided for in a joint protocol with Network Rail). That step should have been, but was not, immediately taken when Chris failed to return. Had the trains been slowed, it is possible that Chris would not have died that night. This failure occurred because of a combination of factors:* *a. the particular risk of Chris going to the railway line was recognised but should have been better communicated and documented so that, if Chris went missing, it was immediately clear to all staff;* *b. the CPFT policy for missing (AWOL) patients was complex and had not been summarised into a shortened ready guide that could be used live during an incident;* *c. there was some confusion as to whether or not the CPFT AWOL policy had superseded the joint protocol with Network Rail which had permitted the signallers to be contacted directly;* *d. the AWOL policies were inadequately trained and then inadequately implemented on the night."* Also relevant to CPFT's involvement in Chris' death, I found that there was an inconsistency of approach in what was recorded as Chris' diagnosis. Having apparently settled on a diagnosis of Emotionally Unstable Personality Disorder and Complex PTSD, I found that it was inappropriate for CPFT to keep reverting to a diagnosis of mixed disorder of conduct and emotions rather than continue to identify Border Personality Disorder (or EUPD) in the diagnosis.
4	**CIRCUMSTANCES OF THE DEATH** In addition to the circumstances evident from the summary of the conclusions and findings set out above, when Sam and Chris were cared for at home (which was, during several periods, the best place for their risk of self-harm/suicide to be managed), the need for vigilance around the clock became extremely challenging for their parents. This involved not just physical supervision but a need for care over medication storage and access, and social media use. Although the First Response Service was available, the parents found that it did not offer sufficient support in practice and Chris' increasing aversion to the emergency services (caused by PTSD) meant that the use of ambulance and police responses was also highly problematic. The family's greatest need was for support in the overnight period, which was a need with which social care services and CPFT were not able, materially, to assist.

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 could 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) **Overnight assistance for adolescent mental health patients being cared for at home but with high levels of need** (**For CPFT and CCC**). I heard evidence of increased funding for CPFT being used to extend home treatment options, but that this would be unlikely to extend to a 24/7 service. I also heard evidence from CCC that available support would now be considered under s17 Children Act or s117 Mental Health Act or both but that this would need to be jointly funded between social care and health. I remain concerned that a clear pathway to securing overnight assistance (even if only on a respite basis) for similar cases of exceptional need has not yet been clearly agreed between CPFT and CCC. I am concerned that if alternative supported accommodation in the community were the best solution, there does not appear to be provision for it in-area, so that admission to a mental health unit becomes more likely. (2) **Involvement of CCC alongside CPFT in complex adolescent mental health cases where the risk is of suicide / self-harm (For CCC)**. In some respects CCC's involvement in Chris and Sam's care (social care and education) lacked direction, focus, knowledge and efficiency. I heard evidence of improvements in training in the relevant education and social work teams, and concerning the new Strong Families, Strong Communities Securing Best Outcomes for Children Strategy (March 2021). Further, that CCC is restructuring all of its early help and adolescent services and will be implementing a formal contextual safeguarding framework and that these developments will be in place by the end of 2021. I am concerned that in the midst of restructuring and new guidance, there remains a risk that education inclusion officers and social workers on the ground may still not have sufficient knowledge, guidance and supervision to ensure that CCC give practical and robust support to parents and adolescent patients, alongside treating healthcare agencies, where the main risk of serious harm to the child is from self-harm or suicide arising from adolescent mental health disorders, rather than neglect of harm by a third party. (3) **Diagnosis of Borderline Personality Disorder (For CPFT)**. I am concerned that the evidence in Chris' case, in particular, suggested a degree of age-related reluctance consistently to use the terminology of Borderline Personality Disorder (or Emerging Personality Disorder or EUPD), even when a highly specialist second opinion had supported this and appeared to have been accepted. There are risks associated with a reluctance to use a personality disorder diagnosis (c.f. Position Statement from the Royal College of Psychiatrists dated January 2020). I received evidence that there have already been some changes/improvements in the preparedness to recognise Borderline Personality Disorder and that further consideration will be given in the context of the new ICD 11. (4) **AWOL patients from Darwin Centre for Young People (For CPFT)**. I heard evidence that since Chris' death, staff have been reminded of the applicable policies; and that an audit has shown good compliance with the provision for calling the local signallers. I heard evidence that there is to be a further review of CPFT's own AWOL policy. I remain concerned that: (i) CPFT's own policy is too lengthy and complex to serve as reference-guidance during a live AWOL incident. In particular the flow chart summary is unnecessarily complex and hard to follow (at least as a tool to consult during a stressful incident); (ii) there is a risk of confusion in having two policies both of which are meant to be followed; (iii) there did not appear be desktop-drills / other training exercises / information grab-packs (etc.) to ensure that all nurses in charge are properly equipped and trained to deal with AWOL incidents efficiently (iv) steps ought to be taken at managerial level to ensure that the confusion over the two policies and whether one had been superseded (evidence of which only emerged during the inquest) cannot recur in this, or other areas, when new policies are introduced.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths: • By CCC in relation to (1) and (2) above; and • By CPFT in relation to (1), (3) and (4), above and I believe your organisations 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 **23 JULY 2021**. 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. NOTE – There are ongoing reporting restrictions that prevent the publication of details regarding the alleged abuser of Sam and Chris. You must not refer to that person's identity in any way in your response and you should contact the Coroner's Officer if you require further guidance in this regard.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons • [redacted] (Parents) • Bottisham Village College • The Village Pharmacy, Fulbourn • Cornford House Surgery and [redacted] • Cambridgeshire Police • British Transport Police • Network Rail and to the LOCAL SAFEGUARDING BOARD. I have also sent it to THE ROYAL COLLEGE OF PSYCHIATRISTS who may find it useful or of interest in relation to the diagnosis issues for Borderline Personality Disorder. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**28 May 2021**

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The National Police Chiefs' Council** (Chief Constable [redacted], Lead for Child Protection)
1	**CORONER** I am NICHOLAS MOSS QC, assistant coroner for the coroner area of CAMBRIDGESHIRE AND PETERBOROUGH.
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. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5 https://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** An investigation commenced on 13 September 2018 into the death of **SAMANTHA JANE GOULD (Sam) aged 16**. The investigation concluded at the end of the inquest on **16 April 2021**. An investigation commenced on 5 February 2019 into the death of **CHRISTINE ELIZABETH GOULD (Chris) aged 17.** The investigation concluded at the end of the inquest on **26 May 2021**. These were separate inquests. • Sam died by suicide by an overdose of prescribed medication on 2 September 2018. • Chris died by suicide when she deliberately stepped in front of a passing train on 26 January 2019. The conclusion in relation to Sam's death was that the main cause of her death was her borderline personality disorder, which treating clinicians assessed to be related to allegations of prolonged sexual abuse in her earlier childhood. The conclusion in relation to Chris' death was that the main cause of her death was: (1) her serious mental health disorder (variously diagnosed as Borderline Personality Disorder, Complex Post Traumatic Stress Disorder and Mixed Disorder of Conduct and Emotions). Treating clinicians assessed this to be related to allegations of prolonged sexual abuse in her earlier childhood. (2) The recent death by suicide of her sister Sam (who also suffered from Borderline Personality Disorder) similarly assessed by clinicians to be related to the allegations of their prolonged sexual abuse. In each case, there was a wider narrative conclusion and factual findings delivered in Open Court.
4	**CIRCUMSTANCES OF THE DEATH** I am prohibited by Statute from appearing to determine any question of criminal liability on the part of a named person. The question whether the alleged sexual abuse of Sam and Chris did in fact take place, and the identity of the alleged abuser were both outside

	of the scope of each inquest. Nevertheless, as recorded in the Record of Inquests in each case, treating clinicians attributed Sam and Chris' mental health disorders to the alleged abuse. In my factual findings in each inquest, I found that Chris had made the disclosure of the alleged abuse in 2016 (at age 14). The allegation was that they had been seriously sexually abused from a very young age (about 5) and into their teenage years. They named the alleged abuser. The disclosure was reported to relevant authorities including the police. The forces involved were the Constabularies of Cambridgeshire and Hampshire, the home forces of the family and the alleged abuser respectively. The criminal investigation was closed against a background that – at the time – Sam and Chris were not wishing to provide an evidential account in a video interview. After their deaths, in part on the basis of evidence arising from the coronial investigation, the criminal investigation was re-opened, however on review of the evidence no charges were brought. I heard received evidence during the investigation and inquest that: • In the absence of an evidential account from Chris or Sam, Hampshire police decided not to interview the alleged abuser (although in similar circumstances, Cambridgeshire police would have done so). • Sam and Chris had been advised not to discuss the alleged abuse in any therapy sessions in case it harmed the ability to prosecute. • When the decision that no further action was to be taken against the alleged abuser was communicated to the family, both Chris and Sam felt invalidated and not believed. • There is no national guidance available to police forces regarding appropriate ongoing communication with the victims of alleged child abuse if they are initially unwilling to provide an evidential account but communicate such a decision while suffering from mental ill health and while still under the age of 18.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows:- It is no part of the inquest process or preventing future deaths process to question independent decisions on whether or not to prosecute. However, I am concerned that, (i) Quite apart from their still young age in 2016, Chris and Sam were both already suffering from significant mental ill health. (ii) Against this background, after their initial decision not to give a video recorded interview was made and communicated to the police, I am concerned that there was: • No follow up between the investigating police forces and the clinicians concerned (or with Sam and Chris' parents) to keep open the option of providing an evidential account at a later stage; • No apparent communication to Sam or Chris or their parents that they could change their minds and provide an evidential account later; • No guidance to the investigating police forces on what should be communicated to victims of alleged child abuse who are both suffering from mental ill health and initially unwilling to provide an evidential account and are still under the age of 18.
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 **23 JULY 2021**. 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. NOTE – There are ongoing reporting restrictions that prevent the publication of details regarding the alleged abuser of Sam and Chris. You must not refer to that person's identity in any way in your response and you should contact the Coroner's Officer if you require further guidance in this regard.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons . • [redacted] (Parents) • Cambridgeshire Police (Note: you may find it useful to liaise with Ch Supt [redacted]) • Bottisham Village College • The Village Pharmacy, Fulbourn • Cornford House Surgery and [redacted] • British Transport Police • Network Rail and to the LOCAL SAFEGUARDING BOARD. I have also sent it to HAMPSHIRE POLICE who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**28 May 2021**