H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** (1) [redacted] Director of Children's Services, Gloucestershire County Council, Shire Hall, Westgate Street, GL1 2TP (2) [redacted] Accountable Officer, Gloucestershire Clinical Commissioning Group, Sanger House, 5220 Valiant Court, Gloucester Business Park, Brockworth, Gloucester, GL3 4FE,
1	**CORONER** I am Katy Skerrett, Senior Coroner for Gloucestershire.
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 12th February 2015, I commenced an investigation into the death of Anielka Agnes Grace Marie Jennings. The investigation concluded at the end of the inquest on the 15th June 2016. The conclusion of the inquest was a short form suicide with narrative conclusion. The medical cause of death was 1A - Vasovagal Inhibition as a result of 1B - Hanging.
4	**CIRCUMSTANCES OF THE DEATH** This 17 year old young lady "Anielka" was diagnosed with cardiomyopathy in March 2010, aged 12 years and she suffered a stroke. She underwent a heart transplant in April 2010. Post procedure she recovered well from a cardiac perspective. However, she developed complicated neuro-psychological problems arising from the brain injury caused by the stroke. Anielka's home life was difficult, and she was often reluctant to engage with professionals. She engaged in risk taking behaviours, which included on occasion self-harming, alcohol, illicit drug use, and becoming involved in inappropriate relationships. In December 2014, Anielka was taken off a child protection plan which had been in place since 2011. Her care was being transitioned from child and young person's services to adult services. Multiple agencies were involved with Anielka's care, and her complex needs were identified. However, no lead professional was identified to coordinate her care. On more than one occasion the agencies did not communicate with each other. This led to missed opportunities to provide a structured care plan for Anielka. In January 2015, Anielka drew on her bedroom walls a number of images which indicated suicidal intent. Local mental health services were not made aware of this. On the 4th February 2015, she attended her final appointment at the children's transplant clinic. She travelled to Great Ormond Street with her father. Her journey was delayed by a fatality occurring on the railway line. She was also very upset after reading a report that referred to her ongoing need for support and services. The following day on the 5th February 2015, she left her father in Gloucester City centre at approximately 1000hrs. She made her way to her training college. She then departed for home. Her father returned home at about 1500 hours and found Anielka hanging by the neck from the bannister. A dressing gown cord had been used as the ligature. Her father cut her down and dialled emergency services. Paramedics arrived shortly thereafter and pronounced Anielka deceased at 1510 hours. Police are satisfied there are no suspicious circumstances. A suicide note was found at scene.

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 **MATTER OF CONCERN** is as follows. – (1) When an individual is being cared for by numerous agencies, in particular when said individual is a child transitioning to adult services, there is no lead/ key professional identified, which can result in a breakdown of communication between the agencies.

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 1600hrs on 22nd August 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 Persons: (1) Shaun Clee, Chief Executive 2gether NHS Foundation Trust, Rikenel, Montpelier, Gloucester, GL1 1LY, (2) [redacted] Community Paediatric Department, The Post Room, Chestnut House, Gloucestershire Royal Hospital, Great Western Road, Gloucester, GL1 3NN (3) Deborah Lee, Chief Executive Gloucestershire Hospitals NHS Foundation Trust, Trust HQ, College Lawn, Cheltenham General Hospital, Sandford Road, Cheltenham, Glos, GL53 7AN, (4) [redacted] Great Ormond Street Hospital for Children NHS Foundation Trust, Inquests and Criminal Cases Co-ordinator, Legal department, 55 Great Ormond Street, London WC1N 3JH 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	Dated 27th June 2016 Signature Ms K Skerrett Senior Coroner for Gloucestershire