Summary of Regulation 28 Report to Prevent Future death: Allison Aules (*died 19.7.22)*

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This is a brief summary of the regulation 28 coroners report into the death of Allison Aules from which you can review the coroner recommendations to health care and consider whether there are changes you could implement in your local NHS trust to address them

Clinical summary

12 yr old girl

Events surrounding death

- History of low mood, anxiety, enuresis, self-harm
- 9 month wait for CAMHS review
- Telephone review despite recommendation for face-to-face.
- No formal assessment of mental state or risk
- Discharged after this appointment with no risk management plan.

Died by suicide, contribute to by neglect

Coroner's Concerns

Under resourcing of the CAMHS service nationally, specifically:

- poor funding
- an increase in referrals
- absence of consultant leadership
- speciality recruitment challenges

Key Themes

- National under resourcing of paediatric services increasing pressure on A&E and gen paediatrics
- "Voice of the Child" should be sought and heard in all assessments
- Robust triage to in-person vs. telephone consultations needed
- Risk assessment tools and discharge safety plans needed for young people with mental health concerns

Local Improvement suggestions from this report

- Improve training in psychosocial history (HEADSSS) & risk assessments for gen paeds/A&E staff

- Co-create with young people a resource of local and national support organisations to signpost young people with mental health problems eg YoungMind, Kooth, Calm Harm;

- Support liaison and integration between local paediatric and psychiatry teams

For full information visit:
https://www.judiciary.uk/prevention-of-future-death-reports/allison-aules-prevention-of-future-deaths-report/
or follow the QR code