Buckinghamshire Coroner's Court
29 Windsor End
Beaconsfield
Buckinghamshire HP9 2JJ

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Corporate Director Buckingham Council Childrens Services, The Gateway, Gatehouse Road, Aylesbury, HP19 8FF
1	**CORONER** I am Ian Wade KC, Assistant Coroner for the Coroner area of Buckinghamshire
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 1st March 2019 the Senior Coroner for Buckinghamshire opened an inquest into the death of Melsadie Adella-Rae Parris, a child aged 3 years. The investigation concluded at the end of the inquest conducted by me between 14th and 30th November 2022. The inquest found that Melsadie died from multiple injuries suffered as the result of being struck by a fast non-stopping train at Taplow Railway Station on 18th February 2019, at a time when she was being held by her adult carer who was also killed in the course of a deliberate act of self harm. The inquest concluded that the adult carer died by suicide, but Melsadie's death was recorded by means of a narrative as hereafter appears.
4	**CIRCUMSTANCES OF THE DEATH** Melsadie was three years old and in the custody care and control of a responsible adult. She was well cared for and loved by that adult. She was equally well cared for and loved by all her relatives. On 23rd October 2018 an alert was raised by her carer that Melsadie had been assaulted, which was investigated appropriately by police and local childrens social services under the provisions of the Children Act 1989, and was discounted. Melsadie remained in the custody of her carer. The social services investigation file remained open and ongoing. During the subsequent period, of not less than

	four months before Melsadie's death, her carer suffered an overt breakdown in mental health such that an episodic psychosis was occasionally manifest, and intentionally concealed, and mild to moderate depression was diagnosed. On 23rd December 2018 her carer exhibited symptoms of acute mental illness which was brought to the attention of the social worker team who took appropriate urgent steps to remove Melsadie from her carer and arrange a mental health assessment for the carer by qualified mental health professionals. On 29th December 2018 Melsadie's carer was appropriately assessed by healthcare professionals and deemed not to be psychotic and to have depression. The carer was discharged from the mental health team on reasonable grounds. Melsadie was restored to that adult's care. Thereafter her carer suffered another deterioration in mental health, the full extent of which was not known to childrens social services who closed their ongoing investigation. In the course of reviewing that decision the childrens social service staff undertaking the investigation were informed of an additional concern about the carer which prompted a review of Melsadie's safety but which was considered not to justify further gathering of evidence or reference of the matter to the mental health service. An opportunity to inspect the carer's home, and to seek evidence from the carer's family of other signs of the carer's developing mental illness, and to liaise with mental health services, was missed. It cannot be concluded that such an opportunity if taken would have made any difference to the outcome. The carer continued to demonstrate capacity and normal function and also provided good care to Melsadie. On 18th February 2019 the carer looked after Melsadie throughout the day with evident good intention. In the evening Melsadie went willingly with the carer to Taplow Train Station where the carer deliberately entered a prohibited area within the station by climbing over a fixed barrier and entering a disused platform through which non-stop trains passed. On the balance of probabilities the carer's intention was to end their own life by the act of jumping into the path of a moving train, which did occur, while at the same time intentionally holding Melsadie and thereby exposing her to the same catastrophic collision with the train, which occurred simultaneously. When this happened it is not possible to determine that the carer was not suffering from such a disease of the mind as to be capable of action but incapable of distinguishing between right and wrong and was therefore likely to be legally insane.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – In the course of the investigation and in evidence in the inquest I found that the social work staff in the childrens services were informed on 9th January 2019 by two separate persons, [redacted] that the adult with daily care of Melsadie had spoken to Melsadie in terms of describing her as evil. On checking with the adult carer, that person admitted to the social worker that the reports were true. The social work team knew that the adult carer had previously been referred to them by emergency services as a result of genuine and valid concerns about the carer's mental health such that the carer was suffering from psychosis. The team had removed Melsadie appropriately while

	awaiting a mental health assessment, which was completed without knowledge of the carer's remark and before the remark was known to children's services. The mental health assessment found that the carer was not psychotic, an opinion which was appropriate on the day of assessment. The social work team had earlier conducted an investigation around an older matter of concern involving Melsadie, but this was unrelated to the mental health of her adult carer, and it had arisen two calendar months before the mental health crisis. In respect of that initial concern the social worker had concluded reasonably that there was no evidence to justify the removal of Melsadie nor continuing concern for her safety, but for logistical reasons their file remained open at the time of the new concerns around the carer's metal health. However the team based their review on investigations conducted some months before the mental health concerns arose and before the remark about evil was made. The team did not conduct a renewed visit to the home, nor seek uptodate information from the family, nor liaise with the mental health team. It is likely that if they had done so they would have discovered more detail of the extent of the carer's mental illness which was indicative of paranoia with depression, linked to concealment of ongoing episodic psychosis. It is possible that a further mental health assessment would have been sought, and arrangements made to remove Melsadie from the custody of the carer. I found that existing guidance and policy recognised and encouraged the need to engage with family to gather information, to make home visits, to liaise with mental health and to treat assessment decisions and verification of file closure as dynamic processes requiring rigorous scrutiny. However, despite the existence of this guidance, the team placed undue reliance on the opinion of the mental health professionals and on old irrelevant investigations. Furthermore, although the department commissioned an independent review of the case, this found that the death could not have been predicted (which I accept), but tended to emphasise perceived shortcomings in the mental health professionals work, without acknowledging the above concerns. In addition it contained factual inaccuracies, such as a failure to identify the revelations of 9th January 2019. The review report was withheld, following complaints by the family as to matters of fact, but the council decided nonetheless to publish an executive summary which maintained the partial reflection of the review conclusions. I am concerned that by so doing the department will persist in a view that its team did not fail to adhere to its own guidance and good practice.
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 ***30th January 2023***. 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 interested persons in the inquest, namely [redacted], Oxford Health Foundation NHS Trust, MTR Crossrail, [redacted] Transport for London, Network Rail and the Office of the Railand Road Regulator. 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 2022** **[SIGNED BY CORONER]**