Regulation 28: Prevention of Future Deaths report

Tallulah Mary Scarlett WILSON (died 14.10.12)

	THIS REPORT IS BEING SENT TO: **1. The Right Honourable Jeremy Hunt MP** **Secretary of State for Health** **Department of Health** **Richmond House** **79 Whitehall** **London SW1A 2NS**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 18 October 2012, one of the assistant coroners for Inner North London commenced an investigation into the death of Tallulah Wilson, a fifteen year old schoolgirl. I concluded the investigation at the end of the inquest on 22 January 2014. The jury made a narrative determination, finding that Tallulah jumped in front of a train, taking her own life. I attach to this report a copy of that narrative.
4	**CIRCUMSTANCES OF THE DEATH**

	The jury found that, as a result of Tallulah's dissatisfaction with her friendship group, she created an online persona. She posted about self harm and suicide. She included photographs that she said were of herself following cutting. Her consultant psychiatrist gave evidence that, with hindsight, it seems that when her Tumblr account was deleted (following her mother's discovery of the damaging nature of her posts), Tallulah may have felt herself to be in some way deleted. Thousands of people had read her posts and she had gained great satisfaction from that. So on the one hand, her internet use may have had a negative impact; and yet on the other hand, preventing her internet use may have had a negative impact. The jury included the following in the narrative determination. "This case has highlighted the importance of online life for young people. We all have a responsibility to gain a better understanding of this, which needs to be achieved through appropriate dialogue. This is a particular challenge for health professionals and educators."
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. Although Tallulah was treated by a number of healthcare professionals, and her mother was extremely concerned about her wellbeing, no person who gave evidence felt that, at the time they were looking after Tallulah, they had a good enough understanding of the evolving way that the internet is used by young people, most particularly in terms of the online life that is quite separate from, but sometimes seems to be used to try to validate, the rest of life. Research; the development of improved clinical practice at a national level, details of which are then disseminated by national training; and risk assessment refinement, all seem to be key. Digital lives basic training and audit is already available, but is not part of standard induction training to raise awareness for all in psychiatric and psychological fields, let alone for all doctors.

	I heard at inquest that the Department of Health has taken the lead nationally on youth suicide prevention, commissioning research exploring the use of the internet and trying to understand the role of social media in youth suicides. It is for this reason that I direct this report to you.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that the Department of Health 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 31 March 2014. 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales; • Ms Sarah Wilson, Tallulah's mother; • Dr Caroline McKenna, associate medical director, Tavistock and Portman NHS Foundation Trust; • Professor Sir Bruce Keogh, national medical director, NHS England; • Professor Dame Sally Davies, Chief Medical Officer for England; • Dr Maggie Atkinson, Children's Commissioner for England; • Professor Sue Bailey, president, Royal College of Psychiatrists; • Dr Richard Graham, consultant adolescent psychiatrist, technology addiction lead, Tavistock Clinic; • UK Council for Child Internet Safety (UKCCIS). 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 Senior Coroner, at the time of your response,

	about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 30.01.14