	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. South Staffordshire and Shropshire NHS Trust** **Head Quarters Mellor House,** **Corporation St,** **Stafford ST16 3SR** **2. Child and Adolescent Mental Health Service East** **Cross Street Clinic,** **Cross Street, Burton-On-Trent,** **DE14 1EG**
1	**CORONER** I am Margaret Joy Jones Assistant Coroner for the coroner area of Staffordshire South
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 8/11/2016 I commenced an investigation into the death of Annabel Mae LEWIS aged 15. The investigation concluded at the end of the inquest on 8/3/2017. The conclusion of the inquest was **Suicide** and the cause of death **1a Asphyxia, 1b External airways obstruction.**
4	**CIRCUMSTANCES OF THE DEATH** **The deceased had been anxious and suffering from low self-esteem for some time. She was concerned about her weight. There had been some recent family relationship difficulties and she experienced peer pressure at school relating to a stormy relationship that she had with her boyfriend. She had been referred to child and adult mental health services (CAMHS) in November 2015 by her GP but that referral was not accepted. She was referred again by her school on the 20th October 2016. The following day she had contact with the CAMHS team who offered her an appointment which she declined because of difficultly accessing the venue. On the 4th November 2016 the CAMHS team attempted unsuccessfully to contact the school referrer. On the same day her family perceived that she returned home from school unhappy. At about 1700 hours she went to her bedroom at her home address, [redacted] saying she had a migraine. At 1710 hours she received a text from her boyfriend saying he wished to end their relationship. At 1713 hours they spoke on the phone and she indicated to him that she was going to kill herself. At about 2200 hours her father went to her bedroom and found her on the bedroom floor with a plastic bag over her head tied underneath her chin. She was certified dead at the 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 **MATTERS OF CONCERN** are as follows. (1) **At the inquest it was evident that Annabel had been referred by her GP to your team in November 2015 but that referral had not been accepted. She was referred again on 20/10/2016 by her school. This time the referral was accepted and your team made contact with her by telephone on 21/10/2016. She declined an appointment because she felt she could not get to the venue. No level of risk was recorded and next of kin details were not available. The date of appointment offered and declined were not recorded. Alternative time for appointment was not recorded. No follow up arrangements were recorded.** **There was no attempt to contact Annabel thereafter. An unsuccessful attempt to contact the referrer was made on 4/11/2016- the day Annabel took her own life.** **The time period between referral and initial contact and attempted follow up appears considerable.** **No attempt appears to have been made to engage with her parents who would have been in a position to assist with transport arrangements.** **The expectation that young people such as Annabel would 'opt in 'to the system may be unrealistic given the difficulties that she had in engaging. Annabel might well have benefitted had she been offered a more proactive service.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 **4/5/2017.** 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:

	[redacted] (Annabel's parents) [redacted] [redacted] The Head Teacher Chase Terrace Technology College Bridgecross Road Burntwood Staffs WS7 2DB and to the: Staffordshire Safeguarding Children Board Wedgwood Building Tipping Street Stafford ST16 2DH 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	**9th March 2017** Signed: Margaret J Jones Assistant Coroner Staffordshire (South) Coroner's Office No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 Fax No: 01785 276128 www.staffordshire.gov.uk sscor@staffordshire.gov.uk