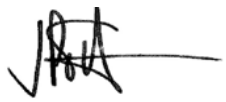
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Mr Neil Carr OBE The Chief Executive of South Staffordshire and Shropshire NHS Trust Trust Headquarters St George's Hospital Corporation Street Stafford ST16 3SR
1	**CORONER** I am John Penhale Ellery, Senior Coroner for the coroner area of Shropshire, Telford & Wrekin
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 31st January 2017 1 commenced an investigation into the death of Jeff David ANTWIS, 14 years of age. The investigation concluded at the end of the inquest on 9th November 2017. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** On Monday 30th January 2017 at approximately 05:30 hours a train travelling south along the railway line at Harlescott level crossing Shrewsbury struck the deceased causing serious head injuries. He was transferred by ambulance to the Royal Stoke University Hospital where at 17:18 hours he was confirmed dead. The deceased was a vulnerable teenager with a diagnosis of asperger's syndrome with a history of self-harm escalating to suicide attempts. In answers to a miracle question he indicated that he wished to die. An urgent medical review was appropriate but not carried out however it cannot be said to have caused or contributed to the death.
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) Following an urgent referral by Jeff's GP to (the then) Shropshire CAMHS on the 10th January 2017 a timely response was made with an initial appointment with a mental health practitioner taking place on the 12th. A

	further appointment was arranged for the 25th January (an earlier date clashed with an existing medical appointment) and in the meantime Jeff was given a miracle question to complete. (2) Jeff answered the miracle question indicating that he wished to die. He passed it to his mother who immediately contacted the mental health practitioner who in turn referred it and the initial assessment to a consultant physiatrist for review. The consultant physiatrist did not consider the matter urgent and arranged for a routine medical review for the 17th March 2017. (3) At the second meeting on the 25th January 2017 Jeff and his mother were informed of the appointment for the 17th March 2017. Jeff's mother immediately raised concerns and asked for it to be brought forward. She was told she would have to write in and make a complaint. This was a time sensitive situation adding to the problem without resolving it. (4) On the 30th January 2017 Jeff killed himself on the railway line. (5) Independent expert evidence from a child and adolescent consultant physiatrist indicated that Jeff should have been offered an urgent medical review appointment for the 27th January 2017 (i.e. within 7 days of the internal referral to the consultant physiatrist) and not, as a routine appointment, the 17th March 2017. It cannot be said that such earlier appointment would have addressed Jeff's problems and altered his wish to die but it is it possible that earlier intervention may have lifted his spirits and not, according to his mother, 'wilted'. It undoubtedly would have helped and at least been an earlier step in seeking to help Jeff. (6) Other matters of concern arose from the evidence. The mental health practitioner: a) Was aware of the deliberate self-harm protocol but not its content. b) Carried out a risk assessment on a subjective basis without reference to any known definition e.g. serious or significant. c) Had no mechanism for referring back to the consultant physiatrist appointment, whether she agreed with the request or not. (7) As stated Jeff had a diagnosis of asperger's syndrome with autistic spectrum disorder. Concerns were raised to what extent these conditions have may have masked Jeff's suicidal ideation on presentation and to what extent, if it is the case, they were recognized. (8) From evidence given at the inquest it is clear that the provision of child and adolescent mental health service is in transition, having moved from Shropshire CAMHS to part of South Staffordshire and Shropshire NHS Trust. Certain actions are already being taken and these concerns are raised so that a holistic approach can be taken and fed in to what is already an ongoing wider review.

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 8th January 2018. 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 [redacted], Solicitors for the family [redacted], father of deceased Mills & Reeve, Solicitors for South Staffordshire and Shropshire NHS Trust [redacted], Consultant Child and Adolescent Physiatrist [redacted], Director of Shropshire Public Health 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	 13th November 2017 J.P. Ellery Senior Coroner Shropshire, Telford & Wrekin Area