	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Secretary of State for Health**
1	**CORONER** Sarah Louise Slater, Assistant Coroner for South Yorkshire (West)
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 (Investigatory) Regulations 2013. (1) Where – a. A senior coroner has been conducting an investigation under this Part into a person's death and b. Anything revealed by the investigation gives rise to concern that circumstances creating a risk or other deaths will occur, or will continue to exist, in the future, and c. In the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have the power to take such action. (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it. (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner
	INVESTIGATION and INQUEST On 25th April 2017 I commenced an investigation into the death of Miss Daisy French. The investigation concluded at the end of the inquest on 8th November 2017. The conclusion of the inquest was that Miss French died from; 1a) Multiple Injuries 2) Asperger's Syndrome A narrative conclusion was recorded as follows: Daisy French died as a result of injuries she received when she was struck by a train at Meadowhall Railway Station. Daisy deliberately placed herself in front of the train but due to her mental illness it is unclear whether she intended to take her own life at this time.

4	**CIRCUMSTANCES OF THE DEATH** Daisy was 12 years old when she was first referred to Child and Adolescent Mental Health Services (CAMHS) in January 2013 following an overdose. Daisy had several and some lengthy admissions to the Becton Centre, a specialist in-patient facility for children and young people with serious mental health issues. Daisy was diagnosed with depression, Asperger's syndrome and non-organic psychosis. Due to the diagnosis of psychosis, Daisy's care was to be transferred from CAMHS to the Early Intervention Service (EIT) which is an adult psychiatric service. This transition started when Daisy was 15 years of age. [redacted], Consultant Psychiatric confirmed this transfer to adult services is in accordance with national guidance but Daisy found this transition difficult and her mental health deteriorated. Daisy was restrained by British transport Police at Meadowhall Railway Station on the 29th November 2016 and the 15th March 2017 because she was trying to get on the tracks, both times she was detained under section 136 of the mental health act and taken to Maple Ward which is an adult psychiatric ward at the Northern General Hospital, Sheffield. [redacted] explained that all out of hour's mental health services for 16 year olds is provided by the adult services. Therefore, although Daisy was well known to the CAMHS and still under their care, when issues occur "out of hours" she was to be considered an adult and therefore was taken to and assessed by Adult Services. The evidence of the adult service practitioners is that they cannot access any CAMHS records and therefore could potentially go into a mental health assessment of a 16 to 18 year old "blind". The practitioners confirmed that was problematic. Although, because Daisy was transitioning between CAMHS and Adults Services they did have access to some records because they can access all adult services records on their own system called "insight". In addition, when Daisy's mental health deteriorated further because she was now aged 16 years she was admitted to a Crisis House for adults rather than being able to access the CAMHS provision or support. Finally, Daisy wanted to try and live independently and a placement was arranged for her to reside in a Young Women's Housing Project. During this placement Daisy was detained under section 136 after trying to get on to the track at Meadowhall Railway Station on the 15th March 2017. Daisy was again taken to the out of hours adult services and was assessed as not requiring detention and she was released back to the housing project where there are no staff on duty. Daisy continued to struggle with her mental health and the transition from CAMHS to adult Services. On the 19th April 2017 daisy deliberately placed herself in from of a high speed train at Meadowhall Railway Station and died as a result of the injuries she sustained.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving raise 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 **MATTER OF CONCERN** for the Secretary of State to consider is as follows: 1) The communication/information sharing between CAMHS and Adult Services. 2) Transition of care from CAMHS to Adult services.

	3) Out of hour's provision for 16 to 18 years. (During working hours they are considered children and therefore are the responsibility of CAMHS, out of hours the same individuals are considered adults and are therefore assessed by and potentially admitted to adult psychiatric units. 4) Placement of an under 18 year old in a Crisis house for adults 5) Returning an under 18 year old to a supported living setting following a mental health act assessment where no staff are on duty at the premises. The Secretary of State for Health is asked to consider whether it is appropriate for the Trust's to review its systems and procedures in place in relation to the mental health services provisions for 16 to 18 years olds because HMAC Mrs Slater is concerned that this situation could occur again.
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 by 4th 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; 1. The parents of Daisy 2. Sheffield Children's Hospital 3. Sheffield Health and Social Care 4. Sheffield Safeguarding Children Board 5. NHS England 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 November 2017** **Louise Slater** Assistant Coroner