	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Sheffield Children's NHS Foundation Trust** **Copied for interest to:** **2. Noah Lomax's family.** **3. The Crookes GP Practice, Sheffield.**
1	**CORONER** I am Angharad Davies, assistant coroner, for the coroner area of 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 (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** An investigation was commenced into Noah Lomax's death on 8 August 2018 and an Inquest was opened the same day. I concluded an inquest on 24 May 2015. The findings of the court were as follows: Medical Cause of death 1(a) Multiple Injuries Conclusion: Suicide
4	**CIRCUMSTANCES OF THE DEATH** Noah was 15 years of age. At the beginning of July 2018 Noah's mother was made aware of online communication between Noah and a friend in which he expressed an intention to take his own life by jumping off a bridge. Noah's mother acted immediately upon this concern and both made an appointment for Noah to see his GP and to attend Door43 an organisation that provides emotional support for young people. Noah's and his mother attended the GP appointment with the specific intention to obtain help by way of a referral to CAMHS. Noah's GP was told that he had suicidal thoughts and had plans to take his own life. Noah's GP completed a written, non-urgent, referral to CAMHS CAMHS processed the referral promptly but the referral contained insufficient information for a risk assessment to be performed Therefore, CAMHS closed

	Noah's referral but invited his GP to provide further information. Noah's GP planned to use the appointment arranged on 6 August 2018 as an opportunity to obtain the further information sought by CAMHS. Noah's family were not notified that CAMHS had declined the referral. The Trust accepted that the process of requesting further information was not sufficiently robust and that telephone contact with the GP should have been made. This would have avoided the need for a re-referral. Had the information been known that Noah was actively making plans to take his own life CAMHS would have categorised his appointment as urgent and seen him within 2 weeks. Assumptions were made regarding the support being offered to Noah by Door43. The Trust accepted that the actual level of support ought to have been confirmed directly between CAMHS and Door43. The Trust accepted that the current referral form does not capture the information required to process referrals without delay. Noah went on holiday with his father and step-mother between 22 July and 29 July 2018. Noah was not seen by CAMHS on his return. On 1 August 2018 Noah was not open with his mother about his plans. Instead of spending the day with friends he travelled, by a pre-planned route, to Conisborough Viaduct. Sometime after 1.30pm Noah took his own life by jumping from the Viaduct.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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. As I made clear during the Inquest I was concerned about the adequacy of the CAMHS, GP referral form. [redacted], Noah's GP, was inexperienced she had not completed a CAMHS referral form before. She accepted that she had not provided sufficient detail in the form. This resulted in CAMHS being unable to assess Noah's risk and declining Noah's referral. This in turn meant that Noah did not receive an appointment with CAMHS before his death. The Trust's investigation report stated that the evidence "*suggests that the current referral form does not capture the information required to process referrals without delay.*" [redacted], CAMHS Clinical Lead, said that there had not been any other problems with the form with GP's not completing them sufficiently. I am not sure how [redacted] is able to be so confident about this.

	I was told that redesigning the form had been considered by the Trust but was told that this was not the answer. Instead, further training has been provided to GPs within the area. Guidance is attached to the form to assist GPs in completing the form. Having carefully considered the evidence I am not satisfied that steps have been put in place to ameliorate the risk identified. Given the realities of the pressures on a GP's day expecting a GP to use their 10 minute appointment to extract sufficient information for the referral and then at some point complete a referral form, with which they may be unfamiliar, creates the risk that relevant information may not be provided. I would invite the Trust to reconsider whether the form could be improved to reduce the risk of inadequate or insufficient information being provided which may result in a delay in care.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or 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 19 July 2019. 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 Noah Lomax's Family, GP, Sheffield Children's Hospital NHS Foundation Trust. 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	**24 May 2019** **Angharad Davies** **Assistant Coroner South Yorkshire (West)**