REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Rt Hon Nicky Morgan Secretary of State for Digital, Culture, Media and Sport** **enquiries@culture.gov.uk**
1	**CORONER** I am Patricia Harding, senior coroner, for the coroner area of Central and South East Kent
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 28th November 2018 I commenced an investigation into the death of Callie Alix Lewis age 24. The investigation concluded at the end of the inquest on 29th November 2019. The conclusion of the inquest was Suicide by carbon monoxide poisoning contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** Callie Lewis had high functioning Aspergers and depression. She had chronic suicidal ideation and had previously researched methods by which she could die but in the month leading up to her death had been actively planning to end her life. Following three failed attempts to hang herself she changed the method by which she intended to take her life to carbon monoxide poisoning which she believed to be a painless and therefore more likely to succeed. Police attended the address where she was staying when concerns were raised by her family who had learned from a third party of some of the detail of Callie's plans. The police called the Mental Health team and Callie spoke to them, agreeing to attend the Crisis team the following day. She was assessed and referred to the Community Mental Health team, the level of risk having been assessed as low. Within hours of the assessment Callie was detained under the Mental Health Act by the police who had again been notified of concerns, Callie being found in possession of some of the items from a 'suicide kit' which she eventually used to kill herself. Callie was taken to a Mental Health Hospital where she was again assessed, the outcome being that she did not require detention but a referral to the Community Mental Health Team for an assessment to take place the following day. The Community team telephoned Callie when they received the referral but did not take any further action when they were not able to contact her. Callie was reported to the police by the Mental Health Team 12 days after the referral by which time she had already travelled to a remote location and killed herself using a variation of the suicide kit that she had originally been detained with which had been adapted as a result of a failed attempt and following advice gained from a suicide forum. A jury found a number of failures by the Mental Health Team to keep Callie safe which amounted to neglect
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 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) Callie was using an online suicide forum, [redacted] (the forum now appears under the internet address [redacted].Through the forum she was able to engage in discussions with other pro-suicide members and obtain advice how to mislead mental health professionals to avoid being sectioned under the Mental Health Act and also how to perfect the methods of taking her life that she had been considering. She was enabled by the advice provided through the forum to frustrate a mental health assessment and thereafter take her life
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 **29th January 2020**. 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], Kent and Medway NHS and Social Care Partnership Trust and the Chief Constable of Kent Police. I have also sent it to Samaritans who may find it useful or of interest. 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	**[DATE] 3rd December 2019 [SIGNED BY CORONER]**