ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Cambridgeshire & Peterborough NHS Foundation Trust** **2. Cambridgeshire County Council**
1	**CORONER** I am Philip Barlow, assistant coroner, for the coroner area of Cambridgeshire & Peterborough
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 April 2020 the coroner commenced an investigation into the death of Daniel France, age 17. The investigation concluded at the end of the inquest on 28 January 2022. Danny was 17 years old and was living at a YMCA hostel. He was on medication for depression and had been referred to secondary mental health services. He had made previous suicide attempts. On 3 April 2020 he [redacted] of his accommodation with the intention of taking his own life. The medical cause of death was asphyxiation by hanging and the conclusion was suicide.
4	**CIRCUMSTANCES OF THE DEATH** Danny was a vulnerable teenager: he had left home and was living in hostel accommodation; he had changed his GP practice; he was trans, had changed his name and had been referred to the Gender Identity Clinic; he had recently been discharged from secondary mental health services in Suffolk and had been referred to mental health services in Cambridge; he had previously been under CAMHS and was now being referred to adult mental health services; he had diagnoses of anxiety and depression and had been prescribed medication; he had made previous suicide attempts and had long term suicidal thoughts; he had sought counselling from IAPT but this was declined because he was considered too high risk; he had been assessed by First Response Service but had been considered as not requiring urgent intervention. Safeguarding referrals about Danny were made to Cambridgeshire County Council in October 2019 and January 2020. Both referrals were closed and it was accepted that the decision to close both referrals was incorrect. In December 2019 Danny's new GP referred him to Cambridgeshire & Peterborough NHS Foundation Trust (CPFT). He had been seen by the Primary Care Mental Health Services but was still awaiting assessment by the Adult Locality Team at the time of his 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 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. – My concern in this case is that a vulnerable young person can be known to the County Council and Mental Health Trust and yet not receive the support they need pending substantive treatment. Danny was repeatedly assessed as not meeting the criteria for urgent intervention and yet the waiting list for psychological therapy was likely to be over a year from point of first presentation. That gap between urgent and non-urgent services is potentially dangerous for a vulnerable young person, where there is a chronic risk of an impulsive act. I understand that there is a long term plan to extend young people's services to age 25, but I remain concerned about the ongoing situation, and that a young person today could be faced with the same challenges in finding support pending substantive treatment. I believe this concern is the combined responsibility of Cambridgeshire County Council and CPFT. These organisations may wish to consult in preparing their response to this report. The inquest heard evidence about the considerable delay in obtaining appointments for the Gender Identity Clinic, and about the shortage of availability for psychological therapies such as CBT. These are matters for policy and funding. This report will therefore be copied to NHS England and The Secretary of State for Health for information purposes only.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 16 April 2022. 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. Danny's family 2. The Kite Trust 3. Dr [redacted], GP 4. East of England Ambulance Trust 5. Norfolk & Suffolk NHS Foundation Trust 6. YMCA I have also sent it to the following who may find it useful or of interest. 7. NHS England 8. Secretary of State for Health 9. the LOCAL SAFEGUARDING BOARD (because the deceased was under 18)]. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

	I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**16 February 2022** **Philip Barlow**