REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: [redacted] **Chief Executive** **NHS England** **PO Cox 16738** **Redditch** **B97 9PT**
1	**CORONER** I am **PENELOPE SCHOFIELD**, Senior Coroner, for the coroner area of **WEST SUSSEX**
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 INQU EST** On 12th April 2020 I commenced an investigation into the death of Charlotte Lucy Swift which concluded at the end of an inquest on 21st April 2021. At the end of the Inquest I concluded with a narrative conclusion namely that "Charlotte died from Natural causes whilst suffering from the condition of anorexia nervosa". Following the Inquest, I indicated that I was minded to make a Regulation 28 report.

4	**CIRCUMSTANCES OF THE DEATH** On 9th April 2020 Charlotte was at her parents home of [redacted] Roundstone Drive, East Preston, West Sussex. In the early evening Charlotte's parents heard a thud in the toilet and went to check on her. They found her slumped in the bathroom. Charlotte was unresponsive. An ambulance was called and life saving techniques were carried out but sadly Charlotte was pronounced deceased at 19.43 hours. Charlotte had been struggling with her mental health since the age of 22 when she was disgnosed with gender dysphoria and she went on to develop an eating disorder. In 2019 real concerns were raised about her weight loss and it was clear that she needed an urgent inpatient bed at a specialist unit. Although a place had been sought for her a date for her admission had not been finalised due to a national shortage of inpatient beds. She had expected an update from her Consultant on the day of her death but due to an administrative error this never happened. Charlotte had been upset by this.

5	**CORONER'S CONCERNS** During 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. – Charlotte was in urgent need of medical treatment by way of an inpatient bed at a specialist unit for those with eating disorders. Although she had been accepted for such a placement a bed did not become available before she died. Evidence heard at the Inquest indicated that there was a national shortage of placements/beds and this was putting individuals at risk of serious harm and possible death.
	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 29th July 2021. 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: - The family of Charlotte Swift Sussex Partnership 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	**Date 11th May 2021**  **Penelope Schofield, Senior Coroner**