	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Neil O'Brien Parliamentary Under Secretary of State Department of Health and Social Care c/0 Ministerial Correspondence and Public Enquiries Unit Department of Health and Social Care 39 Victoria Street London SW1H 0EU United Kingdom **2.** Claire Coutinho, Parliamentary Under Secretary of State Ministerial and Public Communications Division Department for Education Piccadily Gate Manchester M1 2WP **3.** Dame Rachel de Souza Children's Commissioner for England Sanctuary Buildings 20 Great Smith Street London SW1P 3BT
1	**CORONER** I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** The death of [redacted] on 24th September 2022 at his home address was reported to me and I opened an investigation which concluded by way of an inquest held on 29th March 2023.

	I determined that the medical cause of [redacted] death was **1 a Hanging** In box 3 of the Record of Inquest I recorded as follows: **[redacted] He was in the process of being assessed for autism but no diagnosis had yet been made. On Saturday 24th September 2022, and as his family were preparing their evening meal, he [redacted] went up to his bedroom. [redacted] his Parents to enter the room where they found [redacted] unresponsive. [redacted] The [redacted] was not wrapped around the neck. [redacted], which fatally restricted his breathing and he had rapidly lost consciousness. Despite cardio-pulmonary resuscitation efforts from his Father, a neighbour and paramedics he could not be revived and upon arrival at hospital his death was confirmed at18.34. From the available evidence, [redacted] had not intended to end his life.** In box 4 of the Record of Inquest I determined that [redacted] died due to: **MISADVENTURE.**

4	**CIRCUMSTANCES OF THE DEATH**
	
	In addition to the contents of section 3 above, the following is of note:
	• **At the time he died, [redacted] was in the early stages of an assessment process aimed at confirming if he had a diagnosis of autism. His Parents had long suspected he was different from their other children.**
	• **He had attended a review on 23/07/22 with a Consultant Paediatrician, but there was more work to be done.**
	• **His family feel that had he been assessed earlier, and a diagnosis made, they may have been more equipped to deal with [redacted] on his more challenging days.**
	• **The court was informed that he had waited around three years for assessment. This was immensely frustrating. His Parents regularly learned that young people perceived to be more challenging were added to the waiting list at a much later stage, and allocated a place higher up that waiting list, with the inevitable consequence that [redacted] assessment was further delayed.**
	• **In April 2022, there was finally some progress and they became aware that the assessment process was to commence, but as it turned out not in sufficient time for him to have been assessed, diagnosed, and for his Parents to be given the help they feel they needed to support him before he died.**
	• **In a witness statement provided for the inquest, [redacted] Father described some of his character traits including:**
	  • [redacted] *was a very physical, affectionate child;*
	  • *He was interested in the outdoors, nature, wildlife, arts and crafts.*
	  • *He was making excellent academic progress;*
	  • *He was very self-deprecating*

	• *He was a risk taker.* • *He was impulsive.* • **Although the assessment process was in motion by the time he died, his Parents remained of the opinion that once assessed, he would most likely have been diagnosed with Attention Deficit Hyperactivity Disorder [ADHD].**
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 send the report: The **MATTER OF CONCERN** is as follows. – • **With finite resources, it is acknowledged that it may not be possible for all young people to be assessed in as timely a manner as required, but there must surely come a point whereby, notwithstanding those finite resources, the wait for assessment is taking too long.** • **The wait for assessment placed [redacted]at risk, and other children will be similarly at risk in the absence of a timely assessment.** • **It is possible that had he been diagnosed earlier, and with enough time for the relevant professionals to have been able to carry out some meaningful work with him, and had his extremely supportive Parents been given more support, [redacted] death may have been avoided.**
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. Given the approaching holiday period I have extended this period to Tuesday, 23rd May 2023. I, the coroner, may extend the period further. 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] [redacted] Parents] 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	03/04/2023 Signature___ A A Wilson _____ Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**