Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** Gender Identity Clinic NHS England Surrey and Borders NHS Partnership trust The Royal College of General Practitioners
1	**CORONER** I am Sarah Clarke Assistant Coroner for the Brighton and Hove and 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 INQUEST** On 01 June 2022 I commenced an investigation into the death of Alice LITMAN aged 20. The investigation concluded at the end of the inquest on 13 October 2023. The conclusion of the inquest was that: Alice Litman, a 20 year old trans female, was found on the 26th May 2022 [redacted] Brighton, having died as a result of a descent from height. From her early teens it was apparent that Ms Litman had struggled with her mental health. At the age of 17, Ms Litman had made previous attempts to take her own life and was for a time under the care of the Community Adolescent Mental Health Services until she was discharged at the age of 18. At the time she was not considered to meet the threshold for adult mental health services and Ms Litman never sought further assistance from the community mental health services. At the time of her death Alice had been on the waiting list for Gender Identity Services for 1023 days which contributed to a decline in her mental health.
4	**CIRCUMSTANCES OF THE DEATH** Alice Litman, a 20 year old trans female, was found on the 26th May 2022 [redacted], Brighton, having died as a result of a descent from height. From her early teens it was apparent that Ms Litman had struggled with her mental health. At the age of 17, Ms Litman had made previous attempts to take her own life and was for a time under the care of the Community Adolescent Mental Health Services until she was discharged at the age of 18. At the time she was not considered to meet the threshold for adult mental health services and Ms Litman never sought further assistance from the community mental health services. At the time of her death Alice had been on the waiting list for Gender Identity Services for 1023 days which contributed to a decline in her mental health.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: a) The knowledge and training for those in the mental health setting for managing and offering care to those in the transgender community. b) The delays in access to gender affirming healthcare. c) The lack of provision of mental health care for those waiting for gender affirming treatment. d) The lack of clarity for clinicians who are in place to support young transgender individuals in Primary Care e) The lack of clarity for clinicians who are in place to support young transgender individuals in the Mental Health Setting.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/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 January 30, 2024. 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 • Alice Litman's family, • Surrey and Borders Partnership Trust • The Gender Identity Clinic • WellBN • Gender GP 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 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 by the Chief Coroner.
9	**Dated: 5th December 2023** Sarah Clarke