MISS N PERSAUD
HIS MAJESTY'S AREA CORONER
EAST LONDON
East London Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **NHS England**
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East London
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** On 1 April 2021 I commenced an investigation into the death of Amarnih Louis Lewis-Daniel, aged 24 years. The investigation concluded at the end of the inquest on the 30 November 2023. The conclusion of the inquest was a narrative conclusion delivered by a jury: *Amarnih took the action that led to her falling from [redacted] floor window. The evidence does not fully disclose whether she intended the outcome to be fatal.*

4	**CIRCUMSTANCES OF THE DEATH** Amarnih Lewis-Daniel suffered from traits of emotionally unstable personality disorder, mixed anxiety and depression, anger management difficulties and gender dysphoria. She was under assessment for autism spectrum disorder. Amarnih had been referred to the gender identity clinic in August 2018. The inquest heard evidence that Amarnih had suffered bullying and abuse, causing her a great deal of distress. She reported to professionals that she was keen to be accepted by and to receive treatment from the Gender Identity Clinic. Amarnih had sourced hormone medication [redacted] The hormone medication was not supervised by any healthcare professional. In the months leading up to her death, Amarnih's mental state declined, and she came into contact with the police, criminal justice system and mental health professionals. On the 17 March 2021 she jumped [redacted] and sustained fatal injuries in the fall. Amarnih was still awaiting care from the Gender Identity Clinic when she passed away.
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. The inquest heard that there are very long waiting lists for GID clinics. In September 2023, the average waiting time was in the region of 7 years. The expert instructed at the inquest identified that long waiting lists could intensify distress arising from gender dysphoria. 2. The inquest also heard that there is little local support available to patients who are waiting for assessment and treatment by Gender Identity Clinics. 3. There was a lack of clarity as to who is responsible for the wellbeing of the patient during the waiting period, for any distress caused by the gender dysphoria. There was a lack of consensus as to whether it would be the referrer or the GID clinic itself. 4. Local mental health services have very little specialist knowledge as to how best to support a person suffering from GID. 5. Those in attendance at the inquest were unclear about guidance available to GPs and other healthcare professionals to support them with the safe prescribing of bridging hormones, during the lengthy waiting period. The BMA's guidance on the role of GPs in managing patients with gender incongruence (2022) and the Royal College of Psychiatrist's advice relating to bridging prescriptions was not known by the healthcare professionals in attendance at the inquest hearing. There is a concern that primary and secondary/tertiary services are not working optimally, to support those during the lengthy waiting periods.
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 **5 February 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: Family of Amarnih Lewis-Daniel, North-East London Foundation Trust and the Tavistock and Portman Clinic. I have also sent a copy to the local Director of Public Health who may find it useful or of interest and to the CQC. 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	**11 December 2023**