*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Medical Officer, CIOS ICB** **2. The Rt Hon Victoria Atkins MP, Secretary of State for Health and Social Care**
1	**CORONER** I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 9 May 2024, I concluded the inquest into the death of Brandon William Turner, also known as Amelia Turner, who died on 21/6/23 at the age of 21. In accordance with the wishes of his mother who attended inquest, I shall refer to him hereafter as Brandon. I recorded the cause of death as 1a) Asphyxia 1b) Fatal pressure on the neck; II) PTSD; Autism I concluded Brandon died from suicide.
4	**CIRCUMSTANCES OF THE DEATH** Brandon had suffered adverse childhood experiences including neglect and emotional abuse that led to his adoption along with his brother. As he grew into adolescence and then early adulthood mental health difficulties emerged that led to a diagnosis of complex PTSD/emotionally unstable personality disorder. Additionally, he had a diagnosis of autistic spectrum disorder. In total, Brandon had five Mental Health Act assessments between May 2021 and May 2023, to include two on consecutive days on 14 and 15 May 2023, the latter following detention under s136. I heard at inquest that it is contrary to national guidance and local policy to admit someone with PTSD/EUPD into hospital and, absent any other therapeutic option, the consultant psychiatrist referred Brandon to the local CMHT. He was discussed at MDT on 23/5/23 and a duty worker spoke to him on 16/6/23 when a decision was made to put him on the

	CMHT therapy pathway. He was found deceased five days later before any treatment had commenced. On reflection, it was noted that referrals would aim to be actioned within five days but took 16 here. The inquest heard that the CMHT was short-staffed at the time and the Manager concerned was fulfilling two roles.
5	**CORONER'S CONCERNS** During the course of these inquests, the evidence has 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. (1) Shortage of staff. This has been a longstanding concern in Cornwall. I am aware there have been initiatives undertaken nationally and internationally and yet the problem remains. It seems this is not an issue that can be resolved by the local ICB and so this concern is directed to the Secretary of State for her attention and formal response. The following two issues require a response from the ICB and not the Secretary of State. (2) As noted above, the inquest was informed that where patients with complex PTSD/EUPD present in crisis, national and local practice is not to detain in a secure hospital. The inquest also heard that in other areas of the country there is a therapeutic alternative of admission to a day hospital (ie not detained, but somewhere to permit de-escalation) or to a crisis unit/house/café. That option is not currently available in Cornwall. (3) The inquest heard that CPFT is commissioned to assess 140 patients annually for autism. The current waiting list for assessment is in the region of two years. In other words, the demand for the service greatly exceeds the current supply.
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. In relation to (1) above, may I invite the Secretary of State to consider how the persistent shortages of staff within the mental health service in Cornwall may be remedied. In relation to (2) and (3), may I invite the ICB to consider whether the concerns identified require attention, acknowledging that there will be other competing concerns.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6 July 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: [redacted] - mother 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]** **[SIGNED BY CORONER]** **9/5/24**