Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** (1) NHS England (2) National Referral Support Service, NHS Arden and Greater East Midlands Commissioning Support Unit (Arden & GEM).
1	**CORONER** I am Michael Spencer, Assistant Coroner for the coroner area of East 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 27 April 2022 I commenced an investigation into the death of Jason PULMAN aged 15. The investigation concluded at the end of the inquest on 12 April 2024. The conclusion of the inquest was that: Narrative: Jason Pulman died as a result of suicide. Jason died by hanging, potentially through his mental health and gender identity issues. Within this context, it is possible his relationship with his boyfriend exacerbated his low mood. It is also possible Jason may have been prevented from committing suicide if British Transport Police had been notified that Jason was a missing person who was possibly on a train.
4	**CIRCUMSTANCES OF THE DEATH** Jason Pulman was found on 19 April 2022, by a member of the public, [redacted]. He was pronounced dead on the scene.
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: (brief summary of matters of concern) 1. I heard evidence at the inquest that Jason did not receive specialist gender dysphoria treatment because he was on the waiting list for the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Trust. There was also evidence that clinicians did not refer Jason for specialist psychiatric support from Child and Adolescent Mental Health Services (CAMHS) in part because the guidance at the time suggested any specialist gender dysphoria treatment should be provided by GIDS. Jason was awaiting a further assessment from CAMHS at the time of his death. 2. On 10 April 2024, i.e. during the course of the inquest, [redacted] published her report on the independent review of gender identity services for children and young

	people (the Cass review). Her recommendations included that: "*a smaller number of secondary services within CAMHS and paediatrics should be identified initially to act as Designated Local Specialist Services (DLSS) within each area. This would increase the available workforce through a flexible, multi-site staff group working between the DLSS and the regional centre, with the opportunity to provide targeted training and upskilling*." 3. The Arden and GEM has provided an update on its website entitled the "National Referral support Service for the NHS Gender Incongruence Service for Children and Young People". This states: "*The NHS understands it isn't easy having to wait a long time to be seen by gender services, and young people may need some extra support with their mental wellbeing while they wait. The NHS is offering this support, if needed, through local Children and Young People Mental Health services (CYPMH), also known as Children and Adolescent Mental Health Services (CAMHS). People will be contacted to ask if they are happy for their details to be shared with their local CYPMH / CAMH service so they can speak to a professional about how they are feeling. This support offer is voluntary and the people's place on the Children and Young People's Gender Services waiting list will not change. This service will be contacting parents, children and young people on the waiting list by email or post to ask if they wish to access this support between April and May 2024*." 4. During the inquest, I heard evidence from senior management at the CAMHS run by Sussex Partnership Foundation Trust to the effect that (i) they were unaware that enhanced support was being offered via CAMHS and (ii) due to existing pressures on resources the enhanced support would likely have an impact on the already very long wait times for CAMHS treatment, which in turn would give rise to a risk of patients taking their own lives while waiting for treatment. 5. I am concerned that if urgent clarity is not provided to CAMHS teams, patients and parents on the appropriate national referral mechanisms for gender services, and the resources available for those services, there is a risk that the circumstances arising prior to Jason's death could be repeated.
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 June 28, 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 I have also sent it to: (a) Jason's family. (b) The Sussex Partnership Foundation Trust. who may find it useful or of interest. 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: 30/04/2024**  **Michael SPENCER** **Assistant Coroner for** **East Sussex**