ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Calderdale Council**
1	**CORONER** I am Marilyn Whittle, Assistant Coroner, for the coroner area of South Yorkshire (West)
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 19 October 2023 I commenced an investigation into the death of Jacob Lee Shorter, 19 years old. The investigation concluded at the end of the inquest on 18 June 2024. The conclusion of the inquest was suicide. The medical cause of death was 1a multiple injuries including complete disruption of the torso and skull fracture. .
4	**CIRCUMSTANCES OF THE DEATH** Jacob was in long term foster care. Following his 18th birthday he was under the pathways leaving care team. He was subject to an education, health and care plan and was still receiving support from William Henry Smith School and received therapy sessions from them. He was seen by a pathways advisor and had an independent visitor in place. In May and June 2023 professionals meetings concerns were expressed about his low mood and he was encouraged to attend his GP with his foster carer. The GP report confirms there was no low moods or anxiety reports apart from the 24 November 2023 appointment that he attended with his foster carer where treatment was discussed and he wanted to think about his options. His foster carer contacted the local authority in September 2023 after he had told her his feelings had gone downhill and she was not given any strategies to help him. The independent visitor discussed his wellbeing with him on 3 December 2023 where he said he had felt suicidal in the past but did not currently feel this way. This information was not passed on to his foster carer or to the pathways team. He was seen again on 31 December 2023 where he was reported to be doing well and no concerns were raised about his emotional wellbeing.

	On new years day Jacob left home and mentioned about having choices to his foster carer. He did not say where he was going and did not return home. On 1 January 2024 Jacob made his way onto the train tracks at Heeley Loop in Sheffield. He was seen on the track in the four foot area . [redacted] It was dark and raining heavily that evening. The train driver applied the emergency brake. Jacob made no attempt to move. There was no time to sound the horn. Unfortunately the train was unable to stop in time and impacted with Jacob causing fatal injuries. Investigations were undertaken that could not establish how Jacob had accessed the train lines. In that area I heard there is more than standard security, with fences and walls. There is pedestrian access and vehicle access gates, but these were locked and everything was in order.
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) Whilst the Independent Visitor was made aware of previous suicidal ideation this was not passed on to the foster carer or anyone else. Calderdale were unable to tell me of the training they receive or the escalation route for concerns or disclosures of this type. There is a clear risk that if this type of information is not passed on and adequate training is not provided in terms of metal health then this could cause future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 13 August 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: the family of Jacob Lee Shorter 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	**18 June 2024 Marilyn Whittle**