South London Coroner's Court
2nd Floor Davis House
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Telephone 020-8313 1883

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The National Medical Director, NHS England,** [redacted] 2. **Secretary of State for Health and Social Care, the Rt Hon Victoria Atkins MP**
1	**CORONER** I am Sebastian Naughton, Assistant Coroner, for the coroner area of South 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.
3	**INVESTIGATION and INQUEST** On 8 December 2021 an investigation into the death of Sailor (previously known as Sara) COURT, who died following an overdose of [redacted] aged 14 years on 17 September 2021. Sailor was non-binary and chose to be referred to by the pronouns "they / them". The investigation concluded at the end of the inquest on 7 June 2024. The conclusion of the inquest was that Sailor took their life by suicide. At the time of their death, Sailor was on the waiting list for treatment under the Community Child and Adolescent Mental Health Service, which is operated by the South London and Maudsley NHS Foundation Trust ("CAMHS").
4	**CIRCUMSTANCES OF THE DEATH** Sailor was first referred to the CAMHS in October 2020 aged 13 due to low mood and self-harm. The referral was accepted in November 2020. Sailor was advised that the waiting time for the mental health assessment appointment would approximately one year, in November 2021. In fact, after an episode of self-harm in mid 2021 and the intervention of the CAMHS crisis team, the assessment due to take place in around November 2021 was superseded by an earlier assessment in mid 2021, and on 20 August 2021 Sailor and

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	their parents were advised that Sailor had been added to the list for and treatment which at that time was approximately 10 months. Sailor took their life some four weeks later on 17 September 2021 when they were found deceased in their bedroom at home by their parents. Toxicology and circumstantial evidence showed that Sailor had taken an overdose of [redacted] which had been prescribed by their GP. I concluded that the overdose was an intentional act amounting to a suicide.
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 anticipated waiting times before Sailor's assessment (approximately one year) was unacceptably long. (2) The length of time before treatment could be delivered thereafter (approximately 10 months) was unacceptably long. (3) The Court heard evidence that the waiting times for assessment and treatment have not improved since Sailor's death, and in fact both have significantly increased. This means that a teenager referred today into the CAMHS could be waiting for around / upwards of two years before they receive treatment. This is an unacceptably long delay. (4) The Court heard evidence that the Trust is attempting to mitigate the problem by way of a proactive "Keeping in Touch" team with the potential to streamline / re-organise the waiting list. However, due to the number of individuals on the waiting list (estimated to be over 1,000) and the number of staff engaged in the Keeping in Touch team (three) and the scale of the task, I was not re-assured that the Keeping in Touch team could realistically and / or safely assess or re-prioritise those on the waiting list in most urgent need of assessment or treatment. (5) The Court heard evidence that the long waiting lists were a result of a lack of resources which has not kept pace with significantly increased (and increasing) demand.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE**

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	You are under a duty to respond to this report within 56 days of the date of this report, namely by **7 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: 1. Sailor's parents; 2. The Chief Executive of the South London and Maudsley NHS Foundation Trust. I have also sent copies to the following who may find it useful or of interest: - The local safeguarding school (since Sailor was a minor under the age of 18); - The Head Teacher at Sailor's school; - Sailor's GP. 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	**10 June 2024** S. Naylor