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 [redacted], Chief Executive, West Suffolk NHS Foundation Trust** **2 [redacted], Chief Executive, Suffolk and North East Essex Integrated Care Board**
1	**CORONER** I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk
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 20th July 2023 I commenced an investigation touching the death of Erin Louise TILLSLEY aged 14. The Investigation concluded at the end of the Inquest on 31st May 2024. The medical cause of death was confirmed as: 1a Ligature around the neck The Conclusion of the Inquest was that: Narrative Conclusion - Erin Louise Tillsley was described by her family as a bubbly, bright and loving young person who exuded warmth and charisma. A person whose company was uplifting and who had a desire to see the lives of those around her enhanced. Erin initially adjusted well to secondary schooling, however following the restrictions imposed during the COVID pandemic being lifted, she struggled with her attendance although an explanation why this was the case could not be established. Following a difficult period with a friend at the end of 2022, on the 31st December 2022 Erin consumed some of her mother's prescribed medication which Erin described as an overdose. She attended hospital where she was assessed for her physical symptoms. These were not considered serious and she was discharged on the 1st January 2023. Emergency Department staff at the West Suffolk Hospital did not consider a referral to psychiatric liaison services to be appropriate during the admission; however advice was given for a referral by Erin's GP to mental health services. This occurred on the 4th January 2023 with a referral being received by the Norfolk and Suffolk NHS Foundation Trust Wellbeing Hub. The referral was screened and triaged and sent to Child and Family and Young Peoples mental health team (CFYP) for further action. Erin was contacted by the CFYP team on the 3rd May 2023 and arrangements were agreed for her to be referred to a counselling service. Safety netting advice was provided at this time. It has not been possible to establish whether such a referral was made to counselling services and at the time of Erin's death no further contact with mental health services had occurred. Following her return to school in January 2023, Erin's attendance suffered further and in April 2023 it was agreed that she would transfer to another school which it was hoped would improve her attendance levels. This was not the case and her attendance levels

	slipped further and she attended her new school for only 4 days between the end of the May half term break and her death on the 14th July 2023. On the 13th July 2023 Erin attended a meeting at her school with her father where arrangements were discussed to both improve her attendance and resolve a disagreement she had with another pupil in her tutor group. Although initially upset at the commencement of the meeting, Erin was observed to be smiling and cheerful when leaving the meeting. She had agreed to return to school the following day. During the evening of the 13th July Erin was observed at home to be happy and preparing to attend school the next day. On 14th July 2023 Erin was seen by her family during the early morning and showed no signs of being distressed or upset. During telephone calls with her father mid-morning, Erin stated that she would not be attending school and refused, despite attempts to persuade her otherwise by her father, to change her mind. Around 1030am her father became concerned that Erin had stopped responding to text messages or answering her phone and returned home to find Erin suspended by a ligature in her room. Emergency services attended and despite attempts at resuscitation Erin was pronounced deceased at the scene. Police enquiries revealed no suspicious circumstances or third-party involvement in the death. Erin Louise TILLSLEY took her own life.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are recorded in the Narrative Conclusion.
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) Evidence received at Inquest included NICE guideline [NG225]; 'Self-harm: Assessment, Management and Preventing Recurrence.' Published: 07 September 2022. This guidance states inter alia that: "Following triage, patients who have self-harmed should receive the requisite treatment for their physical condition, undergo risk and full psychosocial needs assessment and mental state examination, and referral for further treatment and care as necessary" and "All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment." Evidence was also received in the form of a Joint Policy Document published by Suffolk and North East Essex Integrated Care Board (SNEE) and Suffolk County Council (SCC) (Version 21 – January 2023) titled 'Suffolk and North East Essex Health & Social Care Protocol for the Support of Children and Young People in Crisis.' This Policy document outlined the resources available in circumstances where Young People Present into an Emergency Department (ED) in Suffolk to facilitate NICE recommended urgent and emergency care, including NICE recommended treatment for self-harm. The available resources on a 24/7 basis for all age groups includes the Mental Health Liaison

	Service (MHLS) which offers specialist mental health care in a physical health setting by supporting the work of clinicians working in general health pathways, enabling EDs and wards in general hospitals to assess and support mental health needs as they present or arise among people being cared for in the general health pathway. Evidence received during the course of the Inquest indicated that neither the NICE Guidance nor the SNEE/SCC Policy were applied in relation to the care and treatment extended to Erin in the West Suffolk Hospital Emergency Department during her attendance over the period 31st December 2022 to 1st January 2023. The failure to apply this guidance/policy meant that there was a missed opportunity for mental health services to engage early with a vulnerable child who had presented to the Emergency Department having undertaken an act which she described as an overdose.
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 7th January 2025. 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 Erin Louise TILLSLEY** **Norfolk and Suffolk NHS Foundation Trust** **Thomas Gainsborough Academy** **Ormiston Academy** I may also send a copy of your response to any other person who I believe may find it useful or of interest 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	**Dated: 12/11/2024**  **Darren STEWART OBE** **HM Area Coroner for** **Suffolk**