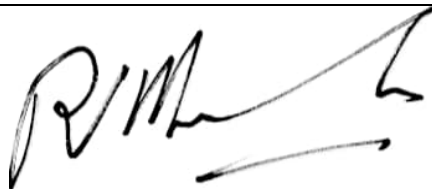
ANNEX A

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. The Chief Executive of the Humber Teaching NHS Foundation Trust**
1	**CORONER** I am Professor Paul Marks, Senior Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.
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 1st July 2021, I commenced an investigation into the death of Eden Anna Street, aged 13 years. The investigation concluded at the end of the inquest on 11th December 2024. The conclusion of the inquest was: **SUICIDE.**
4	**CIRCUMSTANCES OF THE DEATH** Eden Anna Street displayed traits from a very early age which would be consistent with Autism. Several of her family members were also affected with neurodiversity issues. Her Mother was concerned about her behaviour and communication issues and referrals to the Child and Adolescent Mental Health Services took place, although the first referral was rejected. She was also diagnosed with Tourette's Syndrome and when the diagnosis was made, her tics and involuntary movements improved. She was on the waiting list for both creative therapy as well as the East Yorkshire Autistic Service. She received good pastoral support from her school. Despite concern about suicidal thoughts that she had written on the school lavatory wall which resulted in her mother contacting CAMHS, which occasioned an immediate risk assessment to take place, nothing immediate was identified. A decision was made to expedite the start of creative therapy but due to the practitioner's care load being full of cases of equal, if not greater acuity, this did not prove possible. Eden was found suspended by her sister in the bedroom by two belts wrapped around her neck that had been attached to the safety bars of the upper bunk bed. The emergency services attended and continued resuscitation that had been started by her parents, but despite this, she could not be revived and was declared deceased on the night of 27th June 2021. It is not possible to determine on the evidence available whether earlier diagnosis of Autism or the institution of creative therapy would have avoided her death on the day it occurred.

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 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. – Whereas the Humber Teaching NHS Foundation Trust has implemented a number of measures following the publication of a Serious Incident Investigation Report in light of admitted failings, evidence was heard that information provided by parents of autistic children via a telephone helpline operated by the Trust, is not fed back to the weekly audit meeting convened by the Trust. As a result, information about children with neurodiversity issues that might have altered for the worse, may not be available to those who can alter their clinical priorities.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation has 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 March 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: Michelle Moran Humber Teaching Chief Executive; ERYC; safeguarding Children Kingston Upon Hull . I am also sending a copy to NHS England and equivalent organisations in the other countries of the United Kingdom. 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. She may send a copy of this report to any person who she 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	 **10th January 2025**