HERTFORDSHIRE CORONER

The Old Courthouse, St Albans Road East, Hatfield, Hertfordshire, AL10 0ES

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, NHS England** **2. The Chief Executive, Hertfordshire & West Essex Integrated Care Board** **3. The Chief Executive, Hertfordshire County Council**
1	**CORONER** I am Jacques Howell, area coroner, for the coroner area of Hertfordshire
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 March 2021 an investigation was commenced into the death of Joshua Jay Weavers, aged 17. The investigation concluded at the end of the inquest heard by me on 17-19 December 2024 and 20 January 2025. The conclusion of the inquest was: Suicide. The medical cause of death was determined to be: 1a. Multiple Traumatic Injuries.
4	**CIRCUMSTANCES OF THE DEATH** Joshua first came to the attention of mental health services in 2011 due to suicidal ideation and risk-taking behaviour. In October 2017, Joshua went to a railway bridge near his home ([redacted]) with the likely intention of jumping from the bridge and ending his life. He was prevented from doing so by family members who pulled him down the edge. Following this incident, Joshua was re-referred to the mental health team. Initially his treatment consisted of medication and therapy. His therapy sessions stopped in early 2019 after this therapist left the Trust. In March 2019, following funding approval, Joshua was referred for an autism spectrum disorder (ASD) assessment. Whilst awaiting his ASD assessment, a decision in respect of therapeutic intervention for Joshua was put on hold, pending the outcome of the ASD assessment.

	Waiting times for ASD assessments are lengthy, and it was not until the autumn of 2020 that a diagnosis was made with the final assessment report being finalised in January 2021, some 22 months after the referral for assessment. The ASD assessment emphasised the importance of therapeutic intervention for Joshua. A therapy assessment was undertaken in January 2021 by the mental health team which confirmed the need for therapeutic intervention, and Joshua remained on the waiting list for therapy. On 4 March 2021, following the breakdown of a relationship, Joshua went to the railway bridge near his home; the same bridge where he attempted to take his life in 2017. At around 11:36hrs, Joshua jumped from the pedestrian section of the bridge, landing on the railway tracks below where he was subsequently struck by a high-speed train resulting in his death. During the inquest I heard evidence from clinicians from the local mental health NHS Trust and the external NHS Trust who undertakes ASD assessments in Hertfordshire. Their evidence was that the aim of ASD assessments was to assist and guide the provision of effective on-going care and/or treatment needs, as well as being a mechanism to facilitate access to other services. The waiting times for such assessments in Hertfordshire is currently 2.5 years, which is broadly in keeping with the national picture, though there is some variation in waiting times. Crucially, I heard evidence that suicidal behaviours are common in children and adolescents with an eventual diagnosis of ASD (occurring in 10%-50% of cases), and that whilst some patients will be under the care of their local mental health team whilst awaiting assessment, some patients are not. I heard evidence from the local mental health NHS Trust that they have plans to bring ASD assessments in-house with the aim of reducing waiting times for ASD assessment in Hertfordshire, together with plans for more robust monitoring of those awaiting ASD assessment. However, whilst detailed plans have been made, implementation of the same awaits input from the local Integrated Care Board, who commission services. I also heard evidence in relation to the current arrangements in relation to safeguarding pedestrians who use the [redacted]. The evidence was that on the pedestrian walkway the parapet preventing or discouraging pedestrians from jumping or falling from the bridge is low and therefore does not comply with the current guidance from the Office of Rail and Road in this regard. Further, in relation to the vehicular portion of the bridge, I heard evidence that there is also a pavement for pedestrian use, however, as with the dedicated pedestrian walkway, the parapet and other measures preventing or discouraging pedestrians to jump or fall from the bridge does not comply with current guidance from the Office of Rail and Road.
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:

	NHS England 1. That, nationally, waiting times for ASD assessments are very long. Such assessments are important in guiding effective care and treatment, as well as being a potential gateway to access other relevant services. This combined with the fact of an increased risk of suicidal behaviour amongst those who receive a diagnosis of ASD, gives rise to a concern that future deaths may occur on account of the delays in ASD assessment. Hertfordshire Integrated Care Board 2. That whilst the local mental health Trust has plans to reform the manner in which ASD assessments for patients under their care are undertaken, the implementation of those plans awaiting input from the Integrated Care Board. This means that waiting times for ASD assessments in Hertfordshire remain lengthy which in turn gives rise to a risk of future deaths occurring for the reasons set out above. Hertfordshire County Council 3. That the safety measures in place on the [redacted] to guard against pedestrians either jumping or falling from the bridge do not meet current guidance, and therefore gives rise to a risk of future deaths occurring.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe 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 14 April 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: 1. The family 2. Hertfordshire Partnership NHS Foundation Trust 3. Tavistock & Portman NHS Foundation Trust 4. North Hertfordshire College And to the local Safeguarding Board. I have also sent it to the Department of Health and Social Care 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 other 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.
9	 Jacques Howell Area Coroner for Hertfordshire 17 February 2025