Regulation 28: Prevention of Future Deaths report

Charlotte Louise WERNER (died 27.11.24)

	THIS REPORT IS BEING SENT TO: **1. Medical Director** **University College London Hospitals NHS Trust (UCLH)**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Poplar Coroner's Court Bow Coroner's Court
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 29 November 2024, one of my assistant coroners, Richard Brittain, commenced an investigation into the death of Charlotte Louise Werner, aged 13 years. The investigation concluded at the end of the inquest on 28 May 2025. I made a determination at inquest of death by suicide.
4	**CIRCUMSTANCES OF THE DEATH** Charlotte hanged herself at home.
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. Charlotte's mother formed the view that Charlotte was suffering from an eating disorder and was under the impression that the referral to a UCLH dietitian was made, at least in part, in order to explore this. In fact, Charlotte was never diagnosed with an eating disorder, did not meet the criteria for a referral on this basis and was referred solely for consideration of whether her nutritional status was having an impact on her height. I found no evidence of any link between Charlotte's eating and her death. However, that might be different for another child. It seems from the evidence I heard that an explanation, perhaps on the website or in correspondence, that the UCLH dietetic service is not a mental health service and does not treating eating disorders, could be helpful.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 28 July 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 following. • The mother of Charlotte Werner • HHJ Alexia Durran, the Chief Coroner of England & Wales 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. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 02.06.25 *ME Hassell*