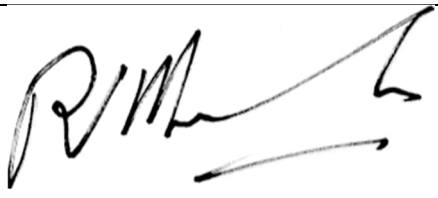
ANNEX A

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. NHS England** **2. Royal College of Psychiatrists** **3. Minister of State, Department of Health and Social Care**
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 8th November 2021, I commenced an investigation into the death of Chloe Louise Barber, aged 18 years. The investigation concluded at the end of the inquest on 18th July 2025. The conclusion of the inquest was: a narrative conclusion (see section 4 below)
4	**CIRCUMSTANCES OF THE DEATH** Chloe Louise Barber had a history of self-harm and of taking multiple overdoses of tablets. She was detained under various sections of the Mental Health Act 1983. Her last admission was to the Cygnet facility in Sheffield where her detention was pursuant to section 3 of the Mental Health Act 1983. Whilst an inpatient, she showed improvement in various aspects of her mental health, probably due to the administration of the atypical antipsychotic drug, aripiprazole. She was at a point in her life where she was making a transition between children's and adolescent mental health services and adult services. She was adamant in her refusal to engage with adult mental health services. Concern exists about the provision of assistance and support measures including S117 aftercare, a care programme approach, capacity assessments and the Vulnerable Adults Risk Management process. There was also valid concern about the lack of documentation and poor communication between services and partner organisations. Whilst many of these matters are true or partially true, no causation flows from them. The issue of cessation of aripiprazole therapy may have more than minimally, trivially or negligibly resulted in increased emotional instability leading to impulsive behaviour, but this was one of a number of issues which may have contributed to her death on 3rd November 2021. Chloe was found [redacted] by her brother at her home address on 3rd November 2021. He cut her down, commenced cardiopulmonary resuscitation and called the ambulance service who attended promptly. Following assessment by the paramedics, Chloe displayed signs unequivocally associated with death and this was confirmed at 17:05 hours on 3rd November 2021. The unpredictability of impulsive behaviour associated with evolving emotionally unstable personality disorder, coupled with Chloe's lack of engagement with provided services or services that may have been

	offered, makes it probable that there was no realistic opportunity to prevent her death. Moreover, there was no indication that she could be detained under any of the provisions of the Mental Health Act 1983, and hence be the subject of compulsory treatment. Whilst her decision to suspend herself may have been impulsive, she nevertheless intended her actions to result in her death.
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. – 1. Evidence was heard at inquest from several expert witnesses that concern exists and continues to exist *nationwide* that there is not necessarily any clearly defined pathway that assists young persons making the transition between Childhood and Adolescent Mental Health Service (CAMHS) and adult psychiatric services, to ensure a smooth transit and continuity of care. 2. Concern was expressed by professional witnesses and experts that there are no clear guidelines about where and by whom depot preparations of antipsychotic may be administered. 3. There was considerable uncertainty and ignorance about the provision of aftercare pursuant to s117 of the Mental Health Act 1983 amongst some healthcare workers and social workers, who should in any event be closely liaising with each other as well as with other allied professionals.
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 October 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 Mr & Mrs Barber; East Riding Yorkshire Council; Humber Mental Health NHS Trust and Cygnet Health Care. 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. 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	 **12th August 2025**