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. **Department of Health and Social Care** 2. **Tavistock and Portman NHS Foundation Trust**
1	**CORONER** I am Mr Andrew Walker, senior coroner for the coroner area of North London.
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 the 11th November 2024 I commenced an investigation into the death of, Leia Dorothy Pandora Sampson-Grimbly aged 17. The investigation concluded at the end of the inquest on 3rd June 2025. The conclusion of the inquest was A consequence of injuries suffered having jumped from a bridge into the water below. The medical cause of death was 1a Massive blood loss, 1b Internal Organ Injuries, 1c Trauma

4	**CIRCUMSTANCES OF THE DEATH** Leia was 17 years old at the time she died a beautiful person inside and out, complex, kind, fair, intelligent, determined, dedicated and talented with a great future ahead of her and greatly loved by all who knew her. Having to battle with changes to her body without receiving the necessary preventative treatment together with the many hurdles and setbacks gradually eroded her belief that she would succeed and everything would be alright. In time this was replaced with increasing thoughts that it could not be fixed and all hope began to fade. Leia reported intermittent low mood in 2024 which may have been a sign of a more serious underlying depressive illness and gender dysphoria which itself can contribute to low mood and be a symptom of a more serious mental health condition. The waiting lists for treatment were far too long and the circumstances therefore led to Leia being without treatment. Leia experienced hostility from certain sections of the community and links on social media inciting those like Leia to suicide. There are multiple factors that led Leia to the point on the 6th November 2024
	where she jumped [redacted] Leia was taken to hospital where despite treatment she died later the same day.
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. – Waiting lists are far too long for first appointment at a Gender Dysphoria clinic.
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 Friday 19th September 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 : [redacted] Family Legal Representative 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	**25th July 2025**