John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW.
1	**CORONER** I am John Adrian Gittins, Senior Coroner for North Wales (East and Central)
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 19th of December 2022 I commenced an investigation into the death of Caitlin Rachel Imber ("Caiti") (DOB 23.3.06 DOD 13.12.22). The investigation concluded at the end of the inquest on the 17th of October 2025. The cause of death was recorded as being due to 1(a) Hanging and the conclusion of the inquest was the following narrative: Around the age of fourteen, Caitlin Imber ('Caiti') fell prey to the [redacted] and criminal exploitation, which despite parental support led to numerous episodes of her going missing and recreational drug use. As a result of this behaviour it became necessary for the local authority to play their part in seeking to keep Caiti safe, and in March 2022, she was placed at [redacted] a residential home [redacted] For the first five or six months of her placement, Caiti largely thrived in this environment, although understandably, she remained significantly traumatized by her previous experiences and as a consequence at the end of August she was appropriately provided with medication, namely sertraline, primarily intended to aid her sleeping. Both the dosage and associated risks of this medication were properly managed, however the anticipated benefits of the same did not materialize. In the Autumn and early Winter of 2022, coinciding with the increased freedoms available to Caiti as a result of her choosing to no longer further her studies in-house, Caiti's mental health deteriorated. Despite this she did not give any significant indications of an intention to self-harm, instead presenting at times as both a typical moody teenager and the child which she still was, excited at the prospect of the coming Christmas. On the 11th of December 2022, unbeknown to those caring for her, Caiti gave an indication to another resident of a wish to harm herself, and whilst she had been upset during the evening of the 12th of December, her presentation did not demonstrate any real and immediate risk to her life. After retiring to her bedroom, Caiti [redacted] resulting in her death which was confirmed on the morning of the 13th of December 2022. Whilst it is not possible from the available evidence to positively establish Caiti's intention by her actions, it is probable that she did not intend to end her life.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are in accordance with the narrative conclusion above.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed the following matter 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 **MATTER OF CONCERN** is as follows. – On the 9th of May 2022, CAMHS received a referral from a community paediatrician dated the 19th of April 2022. This identified the need for support care and treatment to be provided to a traumatized, vulnerable child, however as the referral did not contain any contact numbers, the referral was closed without any additional enquiries being made to further the matter. A further referral was received on the 31st of May 2022 and was then accepted by CAMHS, representing a delay of 42 days from the original paediatrician's referral to any action being taken. Whilst this was not contributory to Caiti's death, I am concerned by the apparent lack of effort to locate missing information and progress a referral and I consider that if this situation continues to prevail, then there is a risk that future deaths could occur.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 19th December 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 Family of the Deceased and to the Chief Coroner. 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	Dated 24th October 2025 Signature [redacted] Senior Coroner for North Wales (East and Central)