West London Coroner Service
25 Bagleys Lane, Fulham, London, SW6 2QA
[redacted]

Date: 5 February 2026 [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Chief Executive West London NHS Trust

Secretary of State for Health and Social Care

CORONER

1 I am **Mrs. Lydia Brown Senior Coroner** for **West London**

CORONER'S LEGAL POWERS

2 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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 12 February 2025 I commenced an investigation into the death of Kallum Josh REED. The investigation concluded at the end of the inquest . The conclusion of the inquest was

3 suicide

1a Hanging

1b

1c

II

CIRCUMSTANCES OF THE DEATH

4 Kallum went missing at around 21:30 11 February 2025. He was deemed a high risk missing person due to suicidal thought and mental health issues. Police conducted search of the area and found Kallum hanging [redacted] Kallum was fully suspended. Kallum was cut down and CPR commenced. Life pronounced extinct at 01:42.

CID attended. Death deemed non-suspicious.

Kallum was under the care of the Mental Health services and on 6th February 2025 presented to the emergency department after an episode of serious deliberate self harm. He was continuing to express suicidal intention.
Referral back to the crisis team (who had been involved in his care until December 2024) was refused and his care remained with the community team. He had been diagnosed after an unacceptedly long wait with autistic spectrum disorder and was still awaiting an ADHD assessment: these two conditions were impactful on how his presentation could have been better understood and managed.

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) The first concern is the "unacceptably long wait" for referrals, assessments and diagnoses of ASD and ADHD. The court was told that demand is continuing to outstrip the services ability to cope; services are outsourced to private providers but there are still unacceptable delays. This impacts the provision of care, the provision of appropriate medication, providing the individuals with insight and understanding of their own presentations and the provision of professional support. In Kallum's case this contributed to the factors that caused his death. **I am therefore raising this concern with the Minister for the DHSC and the WLNHS Trust**

(2) The second concern is that the court was told that the "crisis team" gate-keep referrals into their service, notwithstanding that referral requests can often arise from psychiatry liaison and/or the community psychiatric team who have deep knowledge of the patient and have conducted their own detailed assessments. The care planning in Kallum's case advised him to contact the single point of access (who had rejected referral back to the crisis team in the weeks preceeding the death), to present to ED (which he did but was discharged home to remain under the community team).

The pathways essentially failed as the crisis team still was able to reject the referral, thus effectively closing down an avenue for ongoing close care and communication as the crisis presentation continued. The Trust's internal report concluded that Kallum should have been assessed in person and probably should have been accepted back by the crisis team, but in court this conclusion was contested by the service manager. His evidence was that the crisis team was not appropriate for Kallum and the community team should continue the care. This re-emphasied the challenges faced by patients seeking crisis care as the Trust's own professionals were not in agreement or working collaboratively to find a safe solution. The situation appears not to have changed in the 12 months following this death.

There appears to be no route to access the "half way house" provisions of care unless via the crisis team and so these were not offered or discussed with Kallum or his family who were trying to care for him.

I am therefore raising this concern with the WLNHS Trust

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 April 2026. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons - family members

- Central and North West London NHS Trust.

8 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.

5 February 2026

9 Signature 

Lydia Brown Senior Coroner for West London