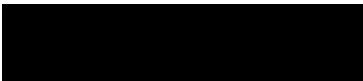


REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

1.	CORONER I am Hannah Berry, Assistant Coroner, for the coroner area of South Yorkshire (West)
2.	DATE OF REPORT 8 May 2026
3.	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.	THIS REPORT IS BEING SENT TO 1. [REDACTED], Chief Executive, Barnsley Metropolitan Borough Council 2. [REDACTED], Chief Executive, South West Yorkshire Partnership NHS Trust 3. [REDACTED], Headmaster, Barnsley Community Academy You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 July 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary .
5.	SUMMARY OF CORONER'S CONCERN There was poor communication and engagement between the agencies involved with supporting Ollie. This led to missed opportunities for Ollie to continue to receive the support of mental health services.

6.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	INVESTIGATION AND INQUEST On 7 October 2024, I commenced an investigation into the death of Ollie Lee, aged 14 years. The inquest concluded on 8 May 2026 with a conclusion of suicide. The medical cause of death was 1a Compression to the neck. The record of inquest recorded that Ollie Lee died on 6 October 2024 at Barnsley District General Hospital from hanging [REDACTED] Ollie had complex needs with suspected neurodiversity, identity confusion and there were concerns she was being bullied at school. On 19 and 26 September 2023 Ollie self harmed at school, on 21 November 2023 she attempted to self ligature and on 4 December 2023 she attempted an overdose. Following these incidents Ollie was supported by the mental health services crisis team until her discharge on 11 March 2024 when it was assessed that she was no longer in crisis. On 4 October 2023 Ollie was put on the waiting list for psycho social intervention from mental health services and was eligible to start this intervention in June 2024. Due to poor communication between agencies Ollie was discharged from the service due to no contact and therefore no psycho social intervention occurred. This was a missed opportunity for Ollie to remain under the care of mental health services. There were additional missed opportunities due to lack of communication when additional self harm attempts were not reported to mental health services. It cannot be said whether the missed opportunity to receive additional support from mental health services caused or contributed to her death.
8.	CIRCUMSTANCES OF DEATH Ollie Lee had complex needs. It was suspected that she was neurodiverse, there was suspicion of borderline personality disorder and at times it was reported that she struggled with body identity. She had changed her and pronouns at varying times in her life. She did not enjoy school and was bullied at times during her time at school. Ollie first voiced suicidal ideation on 9 November 2022 and had sessions with the school counsellor. On 19 September 2023 whilst in school she cut her wrist [REDACTED] A week later on 26 September she used [REDACTED] Following the second incident she was taken to hospital and referred to the child and adolescent mental health service (CAMHS) within South West Yorkshire Partnership NHS Trust and on 4 October 2023 was put on the wait list for psychosocial intervention with CAMHS. On 23 November 2023 she admitted to the school counsellor that she had attempted to self ligature two days prior and on 4

	December she was taken to hospital following an attempted overdose. Following this Ollie and her family were allocated a targeted early help support worker at Barnsley Metropolitan Borough Council. Ollie was supported from the crisis team within CAMHS until she was discharged on 15 February 2024 as it was assessed that she was no longer in crisis. Ollie had a period of absence from school as it was felt that school and bullying were a trigger for her and on 22 February 2024 she returned to education with a carefully managed integration. On 16 April Ollie reported to the deputy designated safeguarding lead at school that she had suicidal thoughts. Early help were notified but CAMHS were not. On 14 May Ollie's early help support worker was notified by Ollie's mother that Ollie was self harming. This was not notified to CAMHS. On 11 June, just over 9 months after Ollie had been put on the wait list for psycho social intervention she was allocated a psychologist. The psychologist was unable to make contact with Ollie's mother by phone or post and so after making enquiries with the school that Ollie was in full time education she was discharged from CAMHS. Neither Ollie's school nor early help were notified of this discharge and remained unaware that Ollie was closed to mental health services. Had early help have been made aware then they would have been able to inform CAMHS that Ollie's mother was having problems with her telephone and of other issues that may have meant that contact could have been made. Ollie and her mother were also unaware that she had been discharged. On 6 June the early help support worker was notified that Ollie had been pulling her hair out. CAMHS were not notified. On 9 September the early help support worker contacted CAMHS to get an update on Ollie's waiting list status and was advised that she had been discharged. On 6 October Ollie took her own life. During the inquest evidence was heard from Ollie's school that Ollie had not asked to be known by anything other than her birth name of Willow at school. Evidence was also heard from early help that engagement had occurred with school on the importance of using Ollie's chosen name and pronouns. There was no record of this being noted and actioned.
9.	CORONER'S CONCERNS During the course of the inquest I heard evidence 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: 1) Poor communication and engagement between the agencies involved with Ollie including her school, CAMHS and targeted early help.

	2) A lack of communication and engagement between targeted early help and CAMHS despite both agencies being aware that the other was involved. This led to a confusing picture and a missed opportunity for Ollie to remain open to CAMHS and receive psycho social intervention and continued support from CAMHS. 3) There was no record of important discussions that occurred between early help and the school and Ollie's preference in relation to pronouns was not acted upon.
10.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. The family of Ollie Lee 2. Chief executive, United Learning I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE  Signature of Hannah Berry H.M Assistant Coroner