REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Anna Loxton, Assistant Coroner, for the coroner area of Surrey.
2.	**DATE OF REPORT** 8th 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.
4.	**THIS REPORT IS BEING SENT TO** 1.Chief Constable, British Transport Police You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 6th July 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**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.
6.	**SUMMARY OF CORONER'S CONCERN** Please see Box 10
7.	**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.
8.	**INVESTIGATION AND INQUEST** On 14th April 2025 Simon Wickens, Area Coroner, commenced an investigation into the death of SHAY MIDDLETON-PIERCE (aged 15). The investigation concluded at the end of a 9-day inquest before a jury on 19th March 2026. The Jury recorded a Narrative Conclusion. Within this, the Jury recorded that Shay died due to "multiple traumatic injuries as a result of suicide on 29th March 2025 at Railway track near to Nutfield train line crossing, Redhill, Surrey". They also recorded the following: "Based on Shay's Snapmaps location which indicated London Bridge area, British Transport Police (BTP) were informed of Shay's possible location and suicidal ideation. BTP graded it as 1 requiring immediate action. BTP deployed a police unit to London Bridge Station but based on the timeline of events Shay was now on a train back towards Redhill. The BTP staff identified the possible train Shay was on and when he may reach Redhill Station also based on Snapmaps update. BTP failed to establish if officers could have been deployed to Redhill Station to meet the train in time. BTP failed to update Surrey Police that they were not attending Redhill Station when the log was moved from the dispatch queue to the sub queue at 14.13 in error." The Jury recorded the following finding in relation to the death as a possible contribution to Shay's death: "There was a failure by British Transport Police to update Surrey Police that they were not attending Redhill Station when the log was moved from the dispatch queue to sub queue at 14.13" (on 28th March 2025).

	The medical cause of death was found to be 1a) Multiple Traumatic Injuries
9.	**CIRCUMSTANCES OF DEATH** Shay Middleton-Pierce failed to attend school on the morning of 28th March 2025, and notified a friend via SnapChat that he had gone to London “because I wanted to die and I know too many spots in Redhill so I came here to make it more effort so I maybe give up”. Shay’s school informed Surrey Police that he was missing and of this information from the friend. Surrey Police were also made aware of Shay’s location, which his friend was able to see on SnapChat. Initially this was at London Bridge Station and British Transport Police (“BTP”) were updated and deployed officers to attend there as a Grade 1 incident. However, Shay then got on a train back to Redhill and Surrey Police updated BTP with this information. The BTP Communications Officer sent the log to the dispatch queue, with the intention that the Dispatcher would then action to police units. However, the Dispatcher moved the log from the dispatch queue to the sub queue, which meant no further action was taken at that time by BTP to establish whether officers could have been deployed to meet the train in time at Redhill Station and Surrey Police were not informed that BTP were not attending. Shay then met friends in Redhill during the course of the day. Shay was not classified as a missing person by Surrey Police until 22.54 on 28th March 2025. Surrey Police did not speak to Shay’s friends until around 22.13 that evening. The officers tasked with looking for Shay were diverted to another incident at 2.46am on 29th March 2025 due to competing demands on the service. No further action was taken to locate Shay until the incident leading to his death occurred on the morning of 29th March 2025, [redacted], sustaining multiple traumatic injuries which were not survivable. The Dispatcher at BTP was unable to explain why he had moved the log to the sub queue other than that this was a human error.
10.	**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 Dispatcher in the Control Room at British Transport Police was unable to explain why he had moved the log from the dispatch queue to the sub queue, other than due to human error. This meant that the log was not treated as a priority and there was a missed opportunity to consider deploying officers to attend Redhill Station to locate Shay, or to update Surrey Police that they would not be attending to see if they were able to deploy officers. The Court heard evidence from the communications officer who had moved the log to the dispatch queue and from the dispatch officer who had moved the log to the sub queue. The Team Manager and Service Delivery Manager for BTP's Force Control Room also gave evidence regarding expectations for dispatchers to deploy a unit or add a significant update before removing the incident from the dispatch queue. These actions did not take place. Following conclusion of the inquest, the Court has heard and received further evidence from a Chief Inspector at BTP that, following an incident in March 2023, where issues were identified concerning lack of command and control where there was a threat to life identified, the Operations Manual was implemented in which it is documented that supervisory oversight is required for all immediate and priority grade calls, and the "CW log must be endorsed by a Force Incident Manager/Deputy Force Incident Manager/Team Manager to confirm their review and supervisory oversight". Further the Court heard that this was subject to a recent review and updated and training was being undertaken to ensure all relevant staff were aware of this. None of the BTP witnesses gave evidence that there was an expectation that Shay's log had to be endorsed in this way by a senior officer and this did not take place despite the learning from the March 2023 incident. The Court has received further evidence from BTP surrounding ongoing training and compliance monitoring in this regard, but given that this incident repeated concerns from the 2023 incident, it appears that further action is required to ensure that a priority log cannot be removed from the dispatch queue to the sub queue as a result of human error by a single dispatcher. The **MATTERS OF CONCERN** are as follows: A dispatcher at BTP can move the log from the dispatch queue to a sub queue in error and this has been documented to have occurred on at least two occasions where a person's life was considered to be at risk. This effectively removes the log from the dispatcher's attention for action. There are no computer checks to prevent this from happening and a system to prevent this with senior officers having oversight of such cases was not referred to in evidence by BTP staff.
11.	**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. Shay Middleton-Pierce's Parents
2. Surrey Police
3. Independent Office for Police Conduct
4. Carrington School

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.