REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Dr Peter Miller** **Chief Executive** **Leicester Partnership NHS Trust**
1	**CORONER** I am Lydia Brown, assistant coroner, for the coroner area of Leicester City and Leicestershire South
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 10 February 2015 I commenced an investigation into the death of William Abel At inquest held on the 18th September 2015 death by suicide was recorded. Cause of death 1a severe head injury
4	**CIRCUMSTANCES OF THE DEATH** Mr Abel was diagnosed with paranoid schizophrenia and was receiving treatment for this severe mental illness. Concerns were raised by the family and general practitioner at the end of December 2014 that his condition appeared to be relapsing and a request was made for an expedited appointment, that he failed to attend. On 8th February 2015 he was reported to be on the railway lines by a member of the public and British Transport and local police attended the scene, removed Mr Abel to a place of safety and arranged a mental health triage team to attend at the local police station to interview him. After the interview it was concluded he was allowed to go home, without criminal charge or any mental health treatment for assessment, with his father. The following day Mr Abel was seen by members of the public to go onto the railway line at t level crossing, despite auditory and visual warnings that a train was coming, and to step in front of a train, where he died instantly.
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 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. Mr Abel had a diagnosis of paranoid schizophrenia and he was still under the care of the Mental Health services at the time he was found in the vicinity of the railway lines, expressing suicidal intention. He had missed appointments and there was a history of non-compliance with medication. Staff were available to have conducted a Mental Health Act assessment, on the night he was safely escorted from the railway lines, but this was not done. 2. Mr Abel was discharged into the care of his father, and inadequate communications were made with the family, as the father was not made aware of the professional concerns regarding a relapse in his mental health, that hospitalisation had been considered and the family was expected to be responsible for his safe keeping. No attempt was made to obtain any family information that could have impacted on the decision to take no further action that night. 3. NICE guidelines (Clinical guidance 136) state that health care professionals should discuss whether the patient would like the family to be involved in their care, and to provide them with information to understand the mental health problem and its treatments. This guideline does not appear to have been met in this case.
	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 15th December 2015. 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 The family of William Abel. British Transport Police. Leicestershire Police. Independent Police Complaints Commission. I am also sending it to the following organisation to whom I believe it may be useful or of interest. CQC 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	**[DATE]** **20th October 2015** **[SIGNED BY CORONER]**