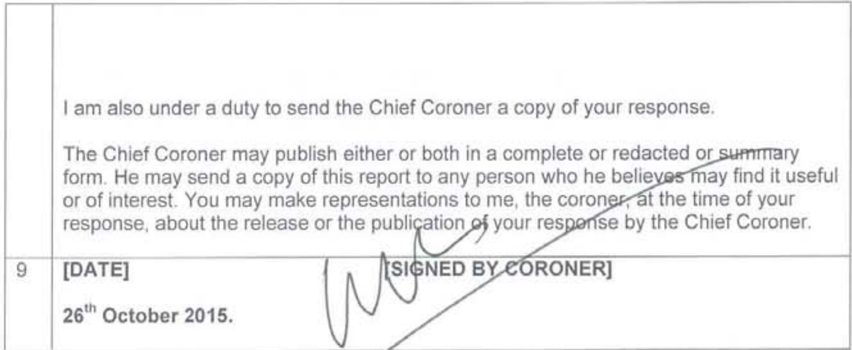
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Sir Peter Soulsby, Mayor, Leicester City Council.** **Dr P. 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 2015 I commenced an investigation into the death of Barry Thraves At inquest it was confirmed that Barry took his own life by hanging and was found deceased on 29 May 2015 at his home address 195 New Parks Boulevard Leicester. At the time he was diagnosed as suffering from a severe mental illness. Cause of death 1a Hanging
4	**CIRCUMSTANCES OF THE DEATH** Barry lived alone, as both his parents whom he had cared for had died. In 2014 he was admitted to the Bradgate Unit, for inpatient psychiatric care and was diagnosed as suffering from schizoaffective disorder, a severe mental illness. He was discharged home on medication with a plan for him to be kept under psychiatric review and to be seen by the community mental health team for support in the community. There was one out patient psychiatric review, but there was then a delay of 4 months until the next appointment. Barry did not attend this and no follow up checks, further appointments or risk considerations were undertaken by the Trust. He was not therefore seen during 2015. In evidence the court was advised that Barry had remained on the waiting list for the Community mental health team, who had made no contact during the 6 months after discharge as they were dealing with higher priority cases. Contact was only made when Barry's sister raised concerns as Barry had relapsed. Following his relapse in May 2015 Barry was assessed but communication between the teams and the family was poor and the arrangements for future contact vague. Barry took his own life at a time unknown but after he was seen on 26th May for assessment; his body being discovered on 29th May.

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. Psychiatric follow up was planned for 2 months but an appointment was not offered for 4 months; on Barry not attending no action was taken and there was no evidence before the court that any clinical consideration of his risks was undertaken at this time. 2. Community support did not take place as planned, and the family were not even made aware that this was awaited and Barry was on the list. It was not clear what, if any, information Barry had received apart from a very brief letter of discharge that specifically did not mention the community support. 3. The expectation of the Local Authority is that appointments should take place within 28 days, but the unit is significantly under-resourced and delays are common and appear to be tolerated, and have been for some time. Earlier, timely appointments could assist in identifying and intervening with relapsing patients. This opportunity was lost. 4. Communication between the community mental health team and other stakeholders was poor, with important information that had been identified (that Barry was depressed and not compliant with his medication) not being shared with the GP, nor were the GP or psychiatric team aware that Barry was not receiving any community support. 5. Information was not made readily available for either Barry, or the family who were trying to support him, of who was involved in his care, the extent of their role and who to contact to discuss this further or in case of any deterioration or change in presentation. This made the task of the supportive sister considerably more onerous and difficult and introduced unnecessary further delays in obtaining support for Barry at a time when his mental health was deteriorating and he was in need of urgent review.
	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 Monday 21st 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 [REDACTED] (Sister) Legal&General Investment Bereavement Team [REDACTED] Customer Services Director, Prudential Insurance



	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]** **[SIGNED BY CORONER]** **26th October 2015.**