REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. John Brouder, Chief Executive, North East London Foundation Trust, Goodmayes Hospital, Barley Lane, Goodmayes, Ilford, Essex, IG3 8XJ** **2. [redacted] Chief Officer, Redbridge CCG, Becketts House, 2-14 Ilford, Ilford, Essex IG1 2QX**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the Coroner area of East London
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 28th July 2015, I commenced an investigation into the death of William Stanley Higgleton. The investigation concluded at the end of the Inquest on the 1st March 2016. The conclusion of the Inquest was a narrative conclusion: *Mr Higgleton suffered anti-social personality disorder and mixed anxiety and depressive disorder. He had reported multiple overdoses in the period November 2013 to March 2015. He was assessed as high risk to self from November 2013 to July 2015. Despite the history of overdoses and the considered high risk to self, his access to medication was not limited. He did not have any support in the community from the mental health team, to assist him with compliance with medication or to assess his mental state more frequently and in his home environment. On the 22nd July 2015 he was found deceased in his home address. Mr Higgleton had taken his own life by ingesting excessing amounts of medication. He had taken his own life while suffering from a mental disorder.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Higgleton had suffered from anti-social personality disorder for many years. He had also suffered from anxiety and depressive disorder for around 5 years prior to his death. He came under the care of the North East London Foundation Trust from November 2013. He was referred to the mental health team at this time, as he had taken an overdose of medication. Mr Higgleton had been seen by [redacted] in June 2014. [redacted] considered the diagnosis to be mixed affective disorder. [redacted] then saw him in October 2014, March 2015 and July 2015. [redacted] considered the diagnosis to be anti-social personality disorder and mixed anxiety and depressive disorder. [redacted] confirmed that Mr Higgleton had complex needs. She did not however consider that he would fit the criteria for CPA or the Community Recovery Team. Mr Higgleton remained under the HAABIT team for 20 months, despite HAABIT being a short-term assessment team

	[redacted] confirmed that throughout her period of caring for Mr Higgleton, he was considered as a long term high risk of harm to self. He had a history of taking overdoses and self-harming by cutting. He also reported in March 2015 taking monthly overdoses with suicidal intent. [redacted] confirmed that the high risk presented by Mr Higgleton had been managed through psychiatric assessments (planned every 2-3 months), prescription of anti-depressive and anti-psychotic medication and by referral to psychotherapy services. During the period of the care under NELFT, Mr Higgleton had not received any psychological therapies. On the 22nd July 2015 Mr Higgleton was found deceased in his bed at home. There is no evidence of any third party involvement in his death and no suspicious circumstances. The toxicology revealed excessive amounts of Citalopram, Tramadol and Mirtazapine in his blood. The pathologist gave a cause of death of 1a multiple drug overdose.
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. – [redacted] considered that Mr Higgleton's primary diagnosis was anti-social personality disorder. She confirmed that the primary treatment for this condition would be psychotherapy services. [redacted] confirmed however that there is a lack of service provision for psychotherapy care to be provided to persons suffering from anti-social personality disorder. The lack of service provision in this regard was confirmed by [redacted] (Assistant Director Adult Mental Health and Learning Disabilities). I consider that the lack of provision of psychotherapy services to this group of patients presents a risk of future deaths occurring.
6	**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 **4 May 2016**. 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 of the deceased). I am also forwarding a copy to report to the Care Quality Commission and to [redacted] (Director of Public Health) who may find it useful or of interest. 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]** 9.3.16 **[SIGNED BY CORONER]**