REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Dr P. Miller, Chief Executive, Leicestershire Partnership NHS Trust.** **[redacted], Managing Director, East Leicestershire & Rutland CCG.** **Rt. Hon. Jeremy Hunt, Secretary of State for Health.**
1	**CORONER** I am Lydia Brown Assistant Coroner, for the 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 4th August 2015 I commenced an investigation into the death of Victoria Georgia Halliday. The Inquest concluded on 23rd September 2016. Cause of death: 1a Hanging
4	**CIRCUMSTANCES OF THE DEATH** Narrative. Vicki's mental health started to deteriorate in the early part of 2015 following a year of stability. She was sectioned under the Mental Health Act and admitted for inpatient care in the Bradgate unit, Leicester for diagnosis and treatment. She was diagnosed with emotionally unstable personality disorder. The plan was to care for Vicki in the community with expected ongoing brief admissions in times of crisis. During June and July 2015 Vicki repeatedly presented in crisis. Numerous missing person reports required police involvement across various geographical locations and she was brought back for psychiatric assessment in Leicester due to concerns for her and the public's safety. On each occasion she was discharged back into the community. There was no effective or robust community support. Ample evidence was available to suggest that Vicki was starting to experience psychotic symptoms from May onwards, but opportunities were missed to fully and adequately explore these and reconsider the necessity for in-patient care. On 29 July the final missing person search was commenced. Vicki was discovered to have taken her own life, but her intent could not be established given the well-documented bizarre thought processes she had been experiencing.

5	**CORONER'S CONCERNS**
	1) There are currently no local psychiatric intensive care unit beds for female patients and this means all female patients can only be placed out of area, potentially many miles away from home and local support. 2) There was no, or no effective, community psychiatric nurse involvement and this was a missed opportunity to monitor and assist Victoria when she was in the community. 3) The "community support" referred to by the in-patient clinicians does not exist in reality for patients with this challenging presentation, leaving discharged patients and their families without adequate support. 4) The care programme approach (CPA) was not adhered to and NICE guidelines were not followed, specifically in ensuring there was a review after 2 admissions within 6 months, and to ensure the roles and responsibilities of all health and social care professionals involved were identified. 5) There is no local network for the community support of patients diagnosed with personality disorder, although evidence suggested such networks were effective when adopted elsewhere.
I.	**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 Thursday 15th December 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] (Father) [redacted] (Uncle) Care Quality Commission (CQC) Milton Keynes Community Health Services Cardiff Adult Mental Health Services. Leicestershire County Council. I am also sending a copy of Jan Bagley, Counsellor 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	**20th October 2016 [SIGNED BY CORONER]**