REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Rt Hon Jeremy Hunt MP, Secretary of State for Health.** [redacted] **Chief Operating Officer, East Leicestershire and Rutland CCG**
1	**CORONER** I am Dianne Hocking 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 10/08/2016 I commenced an investigation into the death of Brandon Singh Rayat, aged 15 years. The investigation concluded at the end of the inquest on 31 August 2017. The conclusion of the inquest was Suicide. Brandon was discovered hanging by a scarf around his neck from a hook in his wardrobe by police who had been called to his home address on the 09 August 2016. He was taken to Leicester Royal Infirmary initially but was then transferred to the Glenfield Hospital, Leicester where he died on the 10 August 2016. He had been receiving treatment from the Child and Adolescent Mental Health Service at the time of his death for low mood and anxiety. Brandon was last seen face to face by one of the treating team on the 31 May 2016 and the final contact with him was on the 03 August 2016. Cause of Death was:- 1a) Severe Hypoxic Ischaemic Encephalopathy 1b) Strangulation by hanging
4	**CIRCUMSTANCES OF THE DEATH** In April 2105 Brandon refused to go to school and became more and more reclusive and anxious. He was taken to the GP by his mum and he was entered into the care of the Child and Adolescent Mental Health Services. He was diagnosed with low mood and anxiety and was treated with fluoxetine. His mental health continued to deteriorate and he refused to engage with any professionals tasked with trying to assist him. His mother went to his mental health appointments alone without her son and the majority of the contact with either her or Brandon was by telephone. At times she managed to get him into the car but when they arrived at the appointment he absolutely refused to get out of the car in order to see the clinician due to his anxieties. Appointments were made appropriately by health care staff but contact with him by health professionals was via occasional telephone calls, when he agreed to speak to them. The last face to face contact with any member of the health care team was on the 31 May 2016 and his suicide occurred on the 09 August 2016. It was established that the efficacy of his care was compromised because of this lack of contact but Brandon was simply too anxious to attend out patients appointments and there was no provision or funding for the clinicians to go to Brandon's home to treat him.

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) That there is no provision of mental health care for children in Leicestershire who due to their anxiety are unable to attend hospital for treatment. There is a CRISIS team for children but I have been told that this cannot fulfil the function of long term treatment.
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 by 01 November 2017. 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] Dr P. Miller, Chief Executive, Leicestershire Partnership NHS Trust Mr J. Adler, Chief Executive, University Hospitals Leicester NHS Trust [redacted] Chief Operating Officer, Leicester City Council Sir David Behan, Chief Executive, Care Quality Commission 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]** **6th September 2017**