REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Clinical Commissioning Group**
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 29th December 2016 I commenced an investigation into the death of Amanda Jaye Briley The Inquest concluded on 7th December 2018 Cause of death: Hypoxic brain injury
4	**CIRCUMSTANCES OF THE DEATH** Amanda Briley was diagnosed with Aspergers and made repeated serious attempts of self-harm. She was detained under the Mental Health Act in an acute psychiatric ward for a period of 7 ½ months, while awaiting a specialist placement to be identified for her. During this time she made repeated attempts to harm herself, in particular by using her clothing to ligature. To maintain her safety, she was nursed on 1:1 observations, but after these were reduced to allow a short period of leave over Christmas, they were not reinstated at this level as they should have been on her return to the ward Amanda Briley was found unconscious in the doorway of her bathroom floor in room 21 on the Beaumont Ward of the Bradgate Unit between 03.05 and 3.10 on the 26th December 2016 with her trousers around her neck. She had last been observed sleeping just after 02.00. Despite resuscitation efforts she die on 28th December 2016 in the Intensive Care Unit of the Leicester Royal Infirmary. The jury returned a very full narrative response to an agreed set of questions, attached to this report for clarity
5	**<u>CORONER'S CONCERNS</u>** The court was advised that CCG have only commissioned services in respect of the diagnosis of autism and not the management of this condition. There is no local in-patient provision and any patient with this diagnosis who requires in-patient mental health treatment would have to be placed out of area. It is a central tenet to the

	Winterboure Report and the Mental Health Act Code of Practise that hospital provision should be as local as possible for individuals to maintain contact with families and communities. I ask that the CCG consider the local provision and given we are geographically so well placed, to consider (if not alone) a collaborative commissioning arrangement based on the Transforming care recommendations.
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 11th March 2018, 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] University Hospitals Leicester Leicester County Council Safeguarding EMAS 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]** 11/1/2019 **[SIGNED BY CORONER]**