REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Ms Amanda Gill, Head of Housing Needs, The Royal Borough of Kensington and Chelsea, Ground Floor Reception, Kensington Town Hall, Hornton Street, London. W8 7NX. [redacted] Chief Operating Officer, Central and North West London NHS Trust, Stephenson House, 75, Hampstead Road, London. NW1 2PL.
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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.
3	**INVESTIGATION and INQUEST** On the 19th and 20th March 2019, evidence was heard touching the death of **Georgia Sylvia Nelson.** Ms Nelson stepped in front of a train at Gloucester Road Underground Station on 11th May 2018. She was 21 years old at the time of her death. The findings of the court were as follows: **Medical Cause of Death** 1 (a) Multiple Injuries **How, when, where and in what circumstances the deceased came by her death:** Georgia suffered with treatment resistant schizophrenia, characterised by severe and persistent positive and negative symptoms. On 11/5/2018 she attended Gloucester Road underground station where at 07:52 she stepped into the path of a train. She was killed instantly. There were no suspicious circumstances. At the time of her death, Georgia was under the care of Kensington and Chelsea Community Mental Health Team and resident in supported housing for young people. On 26/3/2018 she was admitted to St Charles Hospital due to concerns about suicidal ideation, including stepping in front of a train, and other severe symptoms of her illness, following referral from the home treatment team. She had begun to relapse on or about 5/3/2018. Trial of clozapine was attempted in the community then in hospital but was unsuccessful. She was discharged on 13/4/2018 on the same treatment and back to the same accommodation. She left the ward before a discharge planning meeting could take place.

	Her depot medication had not been increased as an inpatient; appropriate discharge planning did not take place and in particular her housing placement was not reviewed and she was not transferred back to the Home Treatment Team. These matters however could not be said to have been causative in her death. The Community Mental Health Team were contacted by her housing provider, her care discussed and transferred to a new care co-ordinator for assessment consideration and depot administration on 24/4/2018. Attempts to engage her in treatment and to come in for assessment and review failed. The care co-ordinator visited her and oversaw the administration of her depot on 4/5/2018 and began a review of her housing. She died before her next planned review. She had denied suicidality on 4/5/2018 but had been visiting suicide websites and called the Samaritans at the end of April. This was unknown to those caring for her. **Conclusion of the Coroner as to the death:** Georgia took her own life whilst suffering with schizophrenia.
4	**Circumstances of the Death.** Extensive evidence was taken in this case and accepted in court; in summary: Georgia had a very long history of severe and enduring mental illness from her teens. She had had two admissions that together totalled more than 18 months of her short life early on in her illness and subsequent admissions. Her illness was treatment resistant and she suffered daily with persistent highly distressing hallucinations and delusions. She was a young woman who was likely to suffer with severe mental illness the whole of her life and was extremely vulnerable. She lived in supported housing for young people which whilst it was not designated as suitable for patients suffering with severe and enduring mental illness was a place where she was safe from exploitation and received caring support from staff who knew her well. Her care was provided by staff operating above and beyond their professional responsibility, and in my view the placement would have been untenable without this dedication. She had lived there longer than the allotted placement time and research had begun to move her on. There was simply no suitable place for her to go. There would appear to be no housing available in the Borough specifically for young people with such mental illness. Housing with mental health support is available on a limited basis but these placements would have been exposed Georgia to potential exploitation due to the range of conditions that other residents suffer with, and the older age of such residents compared to Georgia. There are simply no long term placements available for patients like Georgia, who would in the past have been given community hospital type care. There is also a severe shortage of rehabilitation placements. This lack of suitable housing impacts negatively on the already fragile mental health of the some of the most vulnerable members of society, such as Georgia. In relation to Georgia's discharge following her last admission the evidence was clear that no discharge planning took place. This could have occurred even the absence of Georgia and should occur for all patients especially for one as unwell and vulnerable as Georgia was. The workers at her housing placement attempted to pick up the pieces despite not being a placement that offered specific mental health support from mental health clinicians. There was also a lost opportunity to amend and potentially improve her treatment during her last admission such that she was discharged back on the same meds and to the same social circumstances as those prior to admission. This was especially pertinent since she had had side effects from trial of clozapine, and so would have benefitted from having her antipsychotics amended whilst still an inpatient. The opportunity to discharge her to rehabilitation also appeared to have not been adequately considered.
5	**Concerns of the Coroner:** 1. That there is no suitable housing specifically for young patients with severe and enduring mental illness in RBKC.

	2. There are no long term placements, potentially life long, for any patients requiring supported housing in RBKC with such mental illness. 3. There is a severe shortage of rehabilitation housing placements in RBKC for patients who require them. 4. That there should be a system to ensure that there is proper discharge planning and referral on for all patients discharged after admission with mental illness. 5. That whilst mental health patients are in hospital all opportunities are used to improve their care and treatment and that where possible, they are not discharged before these have been appropriately addressed, rather than discharging them as soon as they are deemed no longer at active risk to themselves or others. 6. That rehabilitation should be more actively considered as a discharge option for patients especially where there are pre-admission concerns about their housing.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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] [redacted] Consultant Psychiatrist, CNWL NHS Foundation Trust, St Charles Hospital [redacted] Community Consultant Psychiatrist, CNWL NHS Foundation Trust, South Kensington and Chelsea Community Mental Health Team, 1 Nightingale Place, London, SW10 9NG. [redacted] Beacon House, 2-4 Bina Gardens, London. SW5 0LA. [redacted] Mental Health Nurse, c/o Nurses Defence Service, Peter House, Oxford Street, Manchester. M1 5AN.

	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	**29th April 2019**  **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Honorary Professor QMUL School of Medicine and Dentistry**