REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** Student Roost Leicestershire Partnership Trust
1	**CORONER** I am Miss F BUTLER, His Majesty's Assistant Coroner for the coroner area of Leicester City and South Leicestershire.
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 16 December 2022 I commenced an investigation into the death of Lily Precious JAHANY aged 18. The investigation concluded at the end of the inquest on 17 May 2024. The conclusion of the inquest was that: Lily Precious Jahany was an 18 year old university student. She was a bright intelligent girl, who was studying to become a Doctor. She resided in student accommodation in Leicester and had been in the city for a period of only 3 months at the time of her death. Lily had a diagnosis of bipolar affective disorder, but also was suffering from post traumatic stress disorder, depression and anxiety, had an underlying eating disorder and whilst not diagnosed with autistic spectrum disorder, demonstrated certain traits associated with the condition, such as rigid thinking and perfectionism. Lily had a lengthy and complicated psychiatric history which was not fully appreciated by those clinicians whose care she came under during her time in Leicester due the lack of a single national medical record for patients, but also the fact that Lily was treated within the private sector. This had the impact of misleading those who treated Lily in the assessment of her risk. But conversely, placed upon them a greater duty and emphasis on ensuring they had at their disposal the relevant information to be able to properly and fully assess Lily's risk, which they failed to do. At the time of her death Lily had been closed to the Crisis Team and was awaiting assessment by the Community Mental Health team for a medication review by a psychiatrist. 3 weeks prior to her death Lily started to suffer manic episodes connected to her bipolar affective disorder. She took 3 overdoses and attempted to ligature on two occasions. Lily would decline hospital admission by the emergency services who attended on her, including on the 8th December 2022, when she was found to be ligating in her room in her student accommodation and paramedics and the police were called. On the 9th December 2022, Lily was found by

	accommodation staff in her room suspended by a ligature around her neck. Emergency services were called, but Lily was declared deceased at 12.35 hours The cause of death was established as: I a Suspension by ligature I b I c II
4	**CIRCUMSTANCES OF THE DEATH** 1. Lily Precious Jahany was an 18 year old medical student who had an extensive background history of mental health difficulties starting as early as the age of 7. She also had an extensive history of previous self harm. Lily was diagnosed with Bipolar Affective Disorder and was treated with Fluoxetine and Lurasidone and had input from a of counsellor. 2. Lily was a highly complex young lady and in addition to her diagnosis of Bipolar Affective Disorder had underlying diagnosis of post traumatic stress disorder caused by the childhood trauma, depression and anxiety. Although not positively on the autistic spectrum disorder, Lily also demonstrated autistic spectrum disorder traits and had an underlying eating disorder. 3. Lily started Leicester University in September 2022. By mid November 2022, Lily started to experience manic episodes connected to her bipolar symptoms and reported taking 3 overdoses on 15, 16 and 18 November. Lily refused to seek medical attention and when she did present to A&E on the 18th discharged herself before being assessed by the Mental Health team. 4. Lily's maladaptive behaviors escalated further and she ligated on 1st December 2022 and again on the 8th December 2022. In the week in between there were other episodes which could be construed as self harm through not eating necessitating ambulances to be called. 5. The extent of Lily's mental health difficulties were not fully appreciated when she arrived in Leicester due to not only the absence of a national single electronic patient record but also because Lily was treated in the private sector and records held by private clinicians are not accessible within a national SystmOne record keeping system. 6. This in my judgment had the impact of misleading those who treated her in the assessment of Lily's risk. But conversely, placed upon them a greater duty and emphasis on ensuring they had at their disposal the relevant information to be able to properly and fully assess Lily's risk. 7. There were failures to obtain the full extent of Lily's mental health challenges and seek information which was pertinent to the assessment of her risk. However, whilst I find there were failures I cannot find on balance that those failures more than minimally trivially or negligibly contributed to Lily's death. 8. At a time unknown between 11pm 8th December 2022 and midday on the 9th December 2022 Lily took increased doses of Zopicone and Promethazine and tied a ligature around her neck and she did so intending to die as a result of her actions. 9. Lily was pronounced deceased at 12.35 hours on the 9th December 2022.

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) (1) Lily resided at student accommodation provided by Student Roost. They describe themselves on their website as '*a student accommodation provider who puts your wellbeing first. Our aim is to provide the very best experience for you to make the most of student living.* Since they were established in 2017, Student Roost has grown to offer 50+ properties across the UK. Student Roost run a 24/7 service including a Night Owl Service which is an excellent idea and provides a 24 hour service to help students with everything from loosing their keys, broken taps, but also their wellbeing. During the course of hearing evidence, it is evident that all of Lily's extreme acts of self-harm took place at her student accommodation. She took at least 3 overdoses and also carried out 2 acts of ligating which she had to be either untied or cut down from. One of those I heard required CPR. I am therefore surprised to learn that no staff (certainly in the 6 properties offering accommodation within Leicester) had first aid training and that it isn't mandatory, such that no staff are trained by Student Roost in first aid. It transpires therefore that any immediate first aid provided to Lily was provided by those who fortuitously had that training from other organisations before they joined Student Roost. In the context of this case but also wider than that, members of the accommodation staff could potentially be the first people at the scene of a situation requiring first aid and then emergency services; where death may occur the fact therefore that they receive no training concerns me. (2) I have spent a lot of time in this inquest investigating the information which was known about Lily, about her mental health and who had access to what information in the context of assessing her risk. In September of 2023, Miss Evans, Assistant Coroner sitting within the Rutland and North Leicestershire jurisdiction heard an inquest concerning a student at Loughborough University. Similar to Lily's case he was under the care of a private psychiatrist elsewhere in the country where he had lived prior to attending university. As a result of concerns in that case (his death occurring 1 year before Lily') around lack of contact by the Crisis Team at the time of assessment or otherwise with the private psychiatrist, the Coroner wrote to the Leicestershire Partnership Trust to share her concerns. The Trust referenced the Crisis Team Standard Operating procedure in the inquest in September 2023, the Coroner was concerned about the level of awareness that staff members had of any expectation required of them set out within that procedure to seek information from other agencies. I now have sight of the Cris Team Standard Operating Procedure. It sets out the keyworker responsibilities. The section is drafted presupposing that patients are receiving care and treatment from the Crisis Team and only at that point does the responsibility for seeking relevant information from other agencies kick in. Furthermore the emphasis upon that requirement is limited to one line which reads '*responsibility for referrals and liaising with other agencies involved'*. That is anything but clear as to any expectation upon staff to ensure they have at their disposal all of the relevant risk information at the time of making that assessment; nor does it in my view set out any expectation upon staff to proactively

	make contact with treating clinicians in the private sector to gain information. It would not capture situations such as Lily's, who was discharged from the Crisis Team after an 1 hour assessment and therefore was not under their care and treatment, I having found a failure to obtain all relevant information pertinent to her risk in assessing that risk.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by July 12, 2024. 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: The family of Lily University of Leicester [redacted] Girls Day School Trust I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 17/05/2024**  **Miss F BUTLER** **His Majesty's Assistant Coroner for Leicester City and South Leicestershire**