

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. Chief Executive, Leicester Partnership Trust NHS Trust</p>
1	<p>CORONER</p> <p>I am Lydia Brown assistant coroner, for the coroner area of Leicester City and Leicestershire South</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 12 December 2012 I commenced an investigation into the death of Laura Page 34 years of age. The investigation concluded at the end of the inquest on 21 May 2014. The conclusion of the inquest was:</p> <p><i>Laura Page experienced a combination of social stresses in November 2012 that led her to seek medical support. Despite clear recognition of her needs the care plan was not carried out by the community team and Laura took an overdose that led to inpatient secure psychiatric care in the Bradgate Unit for 5 days. Her discharge was not completed when she left the unit and was in any event based on inadequate inter-agency communication. No concerns were recognised by any Trust professional in relation to her absence. Laura went home on 4th December 2012, took a substantial overdose and despite seeking medical attention, she died from the consequences of this at 2035 hours in Leicester Royal Infirmary.</i></p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>See above</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p>

	<p>The MATTERS OF CONCERN are as follows. –</p> <p>Ms Page was referred by her GP to the crisis team, who carried out an initial assessment and agreed daily home visits. On 3 separate occasions, different clinicians attended the home address but could not gain access, could not leave a note and did not attempt to contact the client as they had no telephone contact details. These failed visits were not brought to the attention of the shift supervisor that day or the Consultant team meeting the following morning.</p> <p>(1) The clinician response to failed visits is not robust. Further practical efforts could be considered, including door access key fobs where appropriate. (2) The escalation policy should be reviewed to consider specific time targets for action. (3) The threshold for requesting a welfare check should be reconsidered. (4) An analysis of failed visits and untoward outcomes across the service could be maintained and audited to ensure lessons are learnt and best practice shared.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd July 2014. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ul style="list-style-type: none"> ██████████ – mother ██████████ – sister ██████████ – son ██████████ – Guardian for daughter ██████████ – Leicestershire Partnership Trust ██████████ – Leicestershire County Council ██████████ – General Practitioner <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>[DATE] <i>28 May 2014</i> [SIGNED BY CORONER] <i>W/D</i></p>