REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Dr P. Miller, Chief Executive, Leicester Partnership NHS Trust.**
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 24 September 2018 I commenced an investigation into the death of Kim Morris The Inquest concluded on 26th July 2019 Cause of death: 1a Hypoxic brain injury 1b Hanging – suspension by ligature
4	**CIRCUMSTANCES OF THE DEATH** Kim died from the consequences of suspension by ligature; losing her life in the Leicester Royal Infirmary on 22nd September 2018 having been found in the garage at home and resuscitated on 20th September 2018. **Coroners Conclusion:** Kim had been receiving treatment for her mental ill health for many years in primary care and only occasionally in secondary care until she went into crisis during 2018. Admission to the local crisis house was prematurely terminate due to the in-appropriate admission of another patient whose interactions with Kim made her feel unsafe and she therefore lost a positive therapeutic opportunity not only on that occasion but on future occasions as well. She felt unable to engage fully with the crisis team due to a significant lack of continuity of care and this impacted on her negatively. She took her own life the day after that treatment concluded, but her intention at that time was unclear.
5	**CORONER'S CONCERNS** Mrs Morris was referred to the crisis team on more than one occasion but particularly as part of her discharge plan from ward based care in the Bradgate Unit, a mental health hospital during August 2018 having taken a significant overdose. It was clear from the notes that there were numerous visits and telephone encounters, with numerous different individuals, and the role of the key worker did not appear to reduce or impact on the number of different team members having separate contacts with Mrs Morris. It was accepted that she should be referred to a Community psychiatric nurse to continue her engagement and this may bring some continuity of

	only having to speak to and engage with one person. It was not apparent that actual contact had been made prior to her discharge from the crisis team. The court was told that due to the team set up, that continuity of visits was not possible and that the demands on the teams service significantly outweigh the resources available. The service remains on the Trust's "at risk" register. There is no indication in the extensive notes that any efforts were made to alleviate the distress that Mrs Morris felt by having to repeat her story on each occasion to each new team member, or to try and find a better way to engage with her or improve continuity. The handover to the CPN was not carried out in a way that was apparent to Mrs Morris and potentially left her fearful of another delay in receiving help and treatment. She took her life the day after discharge from the crisis team. My concerns are that the team is not offering a service that is suitable to support such high risk individuals and that the expectations of service users are low due to the high and unrelenting pressures and demands on the individuals trying to provide care. This is not a new, but a continuing situation that I have considered before and it remains unresolved.
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 22nd October 2019. 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] (Partner) [redacted]is (Brother) [redacted] (Brother) Mr J. Adler, Chief Executive, University Hospitals of Leicester NHS Trust. 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]** **27th August 2019**