	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Surrey and Borders Partnership Trust** **2. Chair NHS England**
1	**CORONER** Caroline Topping, H.M Assistant Coroner for Surrey
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 30th May 2023 an inquest was opened into the death of Charne Nikita Petit. The inquest was concluded on 30th July 2024. The medical cause of death was: 1a. Suspension. The narrative conclusion was that: Charne Petit suffered from psychotic delusions which she found extremely distressing. From 2019 to 2022 she was treated by the early intervention in psychosis team. Thereafter her care was transferred to the community mental health team. Her symptoms and mood fluctuated, in addition, on occasions, non-compliance with anti-psychotic medication and use of illicit drugs triggered relapses in her mental health. On the 26th March 2023 she suffered a psychotic breakdown and was assessed under the Mental Health Act and found to meet the requirements for detention under s2. No mental health bed was available. She was nursed one to one in the Royal Surrey County Hospital by nurses from the psychiatric liaison team. She was re-started on aripiprazole and her mood stabilized. She was discharged to the home treatment team on the 31st March 2023 without an assessment followed by medical treatment in a mental health hospital. On the 24th April she was seen by her care coordinator and reported intrusive psychotic delusions and struggling to manage her emotions. On the 25th April 2023 she represented to Royal Surrey County Hospital having abused drugs. She was assessed not to require a mental health assessment and discharged. On the 12th May 2023 she killed herself by suspending herself [redacted]. The death was preventable with more effective treatment of her psychosis. The lack of a mental health bed after she was assessed as detainable under s2 more than minimally contributed to the death. She died by Suicide
4	**CIRCUMSTANCES OF THE DEATH** See the details set out in the narrative conclusion. In addition:

	Ms Petit was reviewed in hospital on the 29th March 2023 by a consultant from the liaison psychiatry team. Her presentation had improved since admission and in his opinion, so long as she continued to improve, she could be discharged to the home treatment team and that this was the least restrictive option. The effect of the discharge on the 31st March 2023 was that Ms Petit was not admitted to a mental health hospital under section 2 of the Mental Health Act 1983 and was therefore discharged without having been assessed comprehensively in a mental health hospital.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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. – (1) Evidence given by the court appointed expert consultant psychiatrist was that Ms Petit was not adequately medicalised and that she needed assessment and medical review with optimisation of treatment in a mental health hospital. Her response to treatment needed to be observed. This is what a s2 admission is designed to effect. The lack of a bed in a mental health hospital denied Ms Petit this opportunity for optimal treatment. (2) The Court heard that owing to a shortage of mental health beds patients who have been assessed by 2 s12 consultant psychiatrists to require detention after a mental health act assessment are being effectively detained in general hospitals without a section, awaiting a bed, because they cannot be placed under section unless a mental health bed is available.
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 21st November 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: Chief Coroner Ms Petit's Family Hopewell House Royal Surrey County Hospital I have also sent it to the Royal College of Psychiatrists and Surrey County Council who may find it useful or of interest. 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 other 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.
9	**[DATE]26th September 2024 [SIGNED BY CORONER] Caroline Topping**