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:** **1 Adult Social Care, Leicestershire County Council**
1	**CORONER** I am Sophie LOMAS, Assistant Coroner for the coroner area of Derby and Derbyshire
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 19 September 2019 I commenced an investigation into the death of Alison BINYON aged 24. The investigation concluded at the end of the inquest on 31 October 2024. The conclusion of the inquest was that Alison died due to misadventure. The Medical Cause of Death was: 1 (a) Hypoxic / Ischemic Brain Injury (b) Compression of neck by ligature
4	**CIRCUMSTANCES OF THE DEATH** Alison had a long history of mental health difficulties and a formal diagnosis of Emotionally Unstable Personality Disorder on a background of Post-Traumatic Stress Disorder. At the time of her death Alison was residing in a residential home which offered specialist support for those with enduring mental health illness. She was supported in the home and received psychological therapy. She was also supported by her local Community Mental Health Trust. Alison's living arrangements were on a voluntary basis; there were no restrictions on her movements or liberty. Her placement was funded jointly between the local authority and ICB under s.117 of the Mental Health Act 1983. Alison was content with her living arrangements but in June 2019 a decision was made that her mental health had stabilised and that she would therefore be moving to step-down accommodation at some point in the near future. As part of her condition, Alison regularly engaged in acts of self-harm which included episodes of ligation. Against that background, on the evening of 11th September 2019 a staff member went to check on Alison and and found her unresponsive on her bed [redacted]. An ambulance was called and Alison was taken to hospital where early CT scans showed a suspected hypoxic brain injury. Over the course of the following day Alison's physiological condition continued to deteriorate and tests confirmed death by neurological criteria. She sadly died on the 13th September 2019. The court heard evidence that at the time of her death Alison was experiencing several stressors that were causing her anxiety and making her urges to self-harm stronger. This included anxiety about the move from her residential placement and concerns around her benefit entitlements. It is likely that these factors acted as triggers for the self-harm episdose that led to her death.

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) The court heard evidence from the Adult Social Care Team that communication with service users around moving accommodation needs to be managed carefully as false assurances can undermine trust between the service user and the supporting team. The court further heard that uncertainty can be a potential stressor or trigger for self-harm for those with a diagnosis of Emotionally Unstable Personality Disorder. There is an inherent uncertainty in the timescales for moving as it depends on the availability of suitable accommodation and the situation therefore requires careful management and communication. Whilst consideration had been given to conversations with the service user in this situation, the court heard evidence from those supporting Alison (including community mental health nurses) that they were unclear on the stage the process had reached, the specific steps of the process and the likely timescales involved. This affected the type of support they could provide. There was a lack of evidence of a specific approach or policy addressing how the process can be clearly communicated to those supporting service users in the community. Further, no internal review was carried out at Leicestershire County Council following Alison's death. If such reviews are not conducted this could lead to inadequate learning from deaths which creates a risk of further deaths.
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 January 06, 2025. 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 Alison Binyon** **Derbyshire Healthcare NHS Foundation Trust** **Aspire Health Care** 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: 11/11/2024**  **Sophie LOMAS** **Assistant Coroner for** **Derby and Derbyshire**