RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Date: 30 January 2026

Dear HM, Senior Coroner Rawdon

Re: Miss Mia Maisie Lucas (Regulation 28: Report to Prevent Future Deaths).

Thank you for sending this Regulation 28 Report to the Royal College of Psychiatrists regarding the death of Mia Maisie Lucas.

We are grateful for the opportunity to comment upon this report but before doing that, we would like to extend our deepest sympathies to the family and loved ones of Mia.

The Royal College of Psychiatrists (RCPsych) is the professional medical body responsible for supporting psychiatrists. The College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. The College does not work on the care of individuals and are therefore not able to comment on the specific circumstances surrounding the case of the death of Mia Maisie Lucas.

However, we have considered your findings and have the following comments to make in relation to the issues that you raise.

In addition, we wanted to highlight actions the College has already undertaken in this area and what further activity we plan to take to improve practice in the treatment and care of people with autoimmune encephalitis - particularly at the psychiatry-neurology interface, including issues that are directly relevant in this case.

Overarching Comments

This case illustrates several intersecting challenges, in particular the constraints of current service structures when faced with a rare and complex condition, these are set out below:.

- Autoimmune encephalitis remains an uncommon diagnosis with an evolving evidence base, and most clinicians will encounter very few cases in routine practice.
- Access to and priority of definitive neurological investigations - particularly lumbar puncture and EEG – can be impacted where there are coexisting severe symptoms of mental illness that need to be managed urgently.
- Autoimmune encephalitis sits at the interface between neurology and psychiatry and is typically managed within tertiary neurological services (with integrated neuropsychiatric expertise). Psychiatric inpatient units are generally unable to deliver immunotherapies such as high-dose intravenous corticosteroids, intravenous immunoglobulin, or plasma exchange, while neurology wards are often less equipped to manage extreme behavioural disturbance, psychosis, or aggression. It is also well recognised that patients with autoimmune encephalitis frequently pose substantial management and safety risks on standard neurology wards due to severe behavioural disturbance, psychosis, and agitation, such that neither conventional neurology nor psychiatric inpatient environments alone are consistently fit for purpose without integrated neuropsychiatric expertise.
- You highlight, there has been a lack of clear, nationally agreed guidance specifying when autoimmune encephalitis should be considered, what minimum investigations should be undertaken in secondary care, and when escalation to specialist services should occur.

Actions undertaken and planned to address these.

We very much welcome and agree with the concerns that you raise. The absence of clear, nationally embedded guidance on autoimmune encephalitis - particularly at the psychiatry-neurology interface - has been recognised as a significant gap in clinical practice and service provision.

Independent of this particular tragic case, the College has undertaken the development of national clinical guidance on autoimmune encephalitis and autoimmune psychosis, it is in the final stages of drafting. This work has been undertaken as a priority in response to a recognised national need and is directly relevant to cases such as that of Miss Lucas, in which diagnostic uncertainty and service interface challenges have been shown to carry significant risk.

The guidance has been developed through a College led cross-faculty and cross-specialty process, with formal involvement and agreement across relevant College faculties, including neuropsychiatry, child and adolescent psychiatry, general adult psychiatry, liaison psychiatry, accident, and emergency medicine. Development has also involved national experts in neurology and neuroimmunology, ensuring that recommendations reflect current specialist practice across disciplines.

Crucially, this work has been informed by lived-experience contributors, including individuals affected by autoimmune encephalitis and their families, alongside third-sector organisations representing and supporting those affected by autoimmune encephalitis. This will ensure that the guidance is grounded not only in clinical expertise but also in patient-centred perspectives, particularly regarding early presentation, service navigation, and the consequences of delayed diagnosis.

The guidance is underpinned by the best available contemporary evidence base for this rare condition, including international consensus statements, national and international guidelines, and recent high-quality empirical studies that define the neuropsychiatric phenotype, investigation strategies, and treatment pathways for autoimmune encephalitis and autoimmune psychosis. Where the evidence base is necessarily limited by rarity, recommendations have been developed through transparent expert consensus.

The forthcoming guidance is expected to provide:

- Clear clinical red flag features for autoimmune encephalitis in adult and paediatric mental health settings'
- Adult and paediatric mental health settings
- Explicit recommendations on minimum investigations expected at secondary care level, including guidance on lumbar puncture and EEG in the context of severe behavioural disturbance.
- Defined thresholds for early escalation and referral to specialist neurology and neuroimmunology services, including circumstances in which treatment should not be delayed pending confirmatory antibody results.
- Practical guidance on service interfaces, acknowledging the limitations of both psychiatric and neurological wards and promoting collaborative care pathways.

We anticipate that this national guidance will be formally released within the next six months. Its purpose is to reduce diagnostic ambiguity, support clinicians working in high-pressure secondary care environments, and - most importantly - to reduce the risk of future deaths by facilitating earlier recognition and treatment of autoimmune encephalitis.

In the interim, and consistent with existing national and international guidance, the College continues to emphasise that autoimmune encephalitis is a highly treatable condition when identified promptly. Time to immunotherapy remains the most important predictor of outcome, followed by appropriate neurorehabilitation in specialist services equipped to manage both neurological and psychiatric manifestations.

I do hope that this response is helpful, please come back to us if you would like to discuss any aspects of it.

Yours sincerely,

[redacted]

Professor [redacted]
Registrar [redacted]
Royal College of Psychiatrists