REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: 1. NHS England, PO Box 16738, Redditch, B97 9PT.
1	**CORONER** I am Tanyka Rawden, Senior Coroner for the Coroner area of South Yorkshire (West).
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 31 January 2024 I commenced an investigation into the death of Mia Maisie Lucas, aged 12. The investigation concluded at the end of the inquest on 27 November 2025. The jury concluded with a narrative conclusion finding the medical cause of death to be: 1a. Compression to neck. 1b. Acute psychosis. 1c. Autoimmune Encephalitis. The jury found, inter alia, *"The failure to undertake a Lumbar Puncture at this point meant that potential indicators of Auto Immune Encephalitis were missed. This possibly contributed to Mia's death".*

4	**CIRCUMSTANCES OF THE DEATH** Mia began to demonstrate a change in her behaviour in the months leading up to her hospital admission on 31 December 2023. She reported seeing men in black overalls, hearing voices, and demonstrating behaviour and emotions described as “abnormally extreme” such as hysterically crying one moment and then extremely happy the next. She was scared to sleep alone due to the characters she was seeing. She said one looked like a vampire and was angry, and one was lying on floor looking at her. She said they were watching her and they were always there. She said the characters were telling her what to do and saying they would hurt her family if she didn’t do as they said On one occasion she forcefully putting her fingers up her nose causing it to bleed. She began to punch and spit at her mother, on one occasion trying to take hold of the steering wheel when she was driving On 14 December 2023 Mia attended her GP with symptoms as a viral infection. Her throat was seen to be red, and she was diagnosed with an upper respiratory tract infection. On 31 December 2023 Mia tried to get a knife out of the drawer and said she wanted to kill herself and go to heaven as the voices were telling her to. An ambulance was called, and she was taken to the Queens Medical Centre in Nottingham. After her admission she began to demonstrate manic behaviour, such shouting and running around wards saying the voices telling her to. It was agreed organic causes for her presentation should be ruled out before her mental health symptoms were treated. On 3 January 2024 an MRI was conducted which was reported as normal. On 4 January 2024 all physical investigations were reported as being within a normal range of results despite a remaining plan to conduct a neurology examination and an EEG. A lumbar puncture was not attempted. A neurological examination was competed and reported as normal. On 4 January 2024 discussions were held with Mia about performing an EEG. Mia was not able to engage in the process, and it was not reattempted Autoimmune encephalitis was considered but was felt to have a low index of suspicion. On 4 January 2024 a Mental Health Act Assessment took place, and Mia was detained under Section 2 of the Mental Health Act. It was felt she was suffering from an acute psychotic episode and was a risk to self and others. On 8 January 2024 a test looking for NDMA antibodies was added to the tests requested on Mia’s blood. This was negative. On 9 January Mia 2024 was transferred to the Becton Centre in Sheffield.

	Between 17 January 2024 and the morning of 29 January 2024 there were four incidents of ligating and one incident of self-harm, where Mia pulled out her hair. On 29 January 2024 at 11.30pm staff went to Mia's room to perform observations. The door could not be opened. Assistance was requested, the anti-barricade key was used, and Mia was found unresponsive, pale and blue with a bedsheet around her neck which was wedged between door and door frame. An ambulance was called at 11:36pm and Mia was taken to the emergency dept of the Sheffield Children's Hospital where she was pronounced deceased on 30 January 2024. On 2 February 2024 a postmortem examination was undertaken which identified prominent perivascular lymphoid infiltrates in the temporal and frontal lobes and in the hypothalamus which were T (positive with CD3 and Killer CD8 and B (CD20) positive). On 24 September 2025 a sample of Mia's blood take at postmortem examination was sent to the laboratory for further testing. That sample tested positive for the NMDA Receptor Antibody and Autoimmune Encephalitis was diagnosed.
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: The Court heard there is no national guidance for clinicians on when to consider, and how to diagnose, Autoimmune Encephalitis. Without this I am of the view there is a risk the condition will not be identified which gives rise to a risk that deaths will occur in the future.
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. The initial Report to Prevent Future deaths was issued, inter alia, to the Department of Health and Social Care who tell me you are best placed to respond.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2 April 2026. 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: 1. The maternal family of Mia Maisie Lucas via their representatives. 2. The paternal family of Mia Maisie Lucas. 3. Nottinghamshire Healthcare NHS Foundation Trust. 4. Nottingham University Hospitals NHS Trust.

	5. The Care Quality Commission. 6. The Sheffield Children's NHS Foundation Trust. 7. Sheffield Safeguarding Children Partnership, Floor 2, Howden House 1 Union Street, Sheffield, S1 2SH. 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. She may send a copy of this report to any person who she 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	 **5 February 2026**