REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive – Birmingham & Solihull Mental Health Trust**
1	**CORONER** I am S McGovern, senior coroner, for the coroner area of Warwickshire
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 4 September 2017 I commenced an investigation into the death of Greg HUTCHINS. The investigation concluded at the end of the inquest on 2 May 2018 2018. The conclusion of the inquest was that Mr Hutchins committed suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr Morris committed suicide on 28 August 2017 in a hotel room at Day's Inn, Corley Services Warwickshire. He had suffocated himself with a plastic bag and helium. Thirteen days earlier he had contact with the Street Triage team and I set out my concerns regarding that contact below
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 will 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) the staff member who conducted the telephone triage had no recollection of the triage whatsoever (2) no contemporaneous of the triage were made (3) no subsequent notes were made of the triage (4) no update regarding the triage was made in RIO system (5) the purpose of the telephone triage was unclear – it was described as not being a mental health assessment (6) Mr Hutchins was from outside the Birmingham area and I hear evidence that no national system exists for rapid information sharing
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you as Chief Executive of the Trust 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 26 June 2018. 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 (a) [redacted] (via [redacted] -Aunt of the Deceased) and [redacted] (a close friend of Deceased). 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	**2 May 2018** **Senior Coroner S McGovern** S McGovern