	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) Birmingham Women's and Children's NHS Foundation Trust (Forward Thinking Birmingham).** **2) Birmingham & Solihull Clinical Commissioning Group.**
1	**CORONER** I am James Bennett Assistant Coroner for **Birmingham and Solihull.**
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 03/05/2018 I commenced an investigation into the death of Daniel Hubert Collins. The investigation concluded at the end of an inquest on 31/08/18. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased had no known mental health issues prior to attempting to take his own life via an overdose on 07/04/18 when he was admitted to Hospital. He reported being concerned about the poor health of relatives, that his relationship with his girlfriend had ended and the pressure of completing his degree. He was assessed by RAID nurses on 8 and 9/04/18 and discharged from Hospital on 9/04/18, and because of his young age, was referred to the Forward Thinking Birmingham (FTB) crisis team. An FTB crisis team nurse attended his home on 10/04/18, assessed him, and discharged him from the FTB crisis team to mental health service counselling, putting responsibility on the Deceased to make contact with them. There was no follow up from the FTB crisis team generally, or to check that he had contacted the counselling service. On 25/04/18 he attended a meeting requested by his university to discuss concerns about his wellbeing and mental health. On 26/04/18 he went missing and he was found deceased on 28/04/18 in an area of woodland in Moseley Bog having taken a deliberate overdose. Following a post mortem the medical cause of death was determined to be: VENLAFAXINE OVERDOSE
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: One mental health service, FTB crisis team, transferred necessary mental health care to a second service Living Well Consortium (LWC), putting the responsibility of making contact on the patient (aged 22, and only 72 hours post-attempting to take his own life). The rational was "it is part of their recovery, empowers them and gives them choices". FTB crisis team did not alert LWC to the transfer and did not follow up with LWC or the patient that contact had been made. There was/is no system in place to require FTB crisis team to notify LWC about the transfer or trigger a follow up with LWC/the patient. Therefore, patients are at risk of being lost to the mental health service whilst in crisis/only recently out of crisis.

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 9 November 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: 1) Daniel Hubert Collins' next of kin. I have also sent it to the following who may find it useful or of interest: 1) [redacted] GP. Stratford House Surgery, 578 Stratford Road, Sparkhill, Birmingham, B11 4AN. 2) Living Well Consortium. 3) Birmingham & Solihull Mental Health NHS Foundation Trust 4) NHS England 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	14th September 2018 Signature James Bennett Assistant Coroner **Birmingham and Solihull**