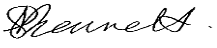
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. NHS England 2. Birmingham and Solihull Clinical Commissioning Group
1	**CORONER** I am Mr James Bennett HM Assistant Coroner for Birmingham and Solihull.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 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 25/10/2018 I commenced an investigation into the death of Anthony John William Watson. The investigation concluded at the end of an inquest on 29/01/19. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was diagnosed with recurrent depression and anxiety in early 2017 and was being treated by mental health services. In mid-May his mental health declined quickly and by 18/10/18 he was displaying signs of psychosis, and reporting that he was thinking of taking his own life by jumping from a height. Mental health services felt that an immediate admission was necessary, but no bed was available within the area, and he was placed on a waiting list. To mitigate the risk of the Deceased harming himself whilst awaiting a bed, he was referred to community mental health services who visited him at home on 18, 19 and 20. A visit was planned for the afternoon on 21/10/18. On the morning of 21/10/18 the Deceased was at home and in his first floor bedroom, he cut both wrists and his neck, and jumped through an open window, landing on the patio causing a significant head injury. He had left a note indicating an intention to end his own life. He was taken by paramedics to Queen Elizabeth Hospital, Birmingham. A CT-scan revealed the fall from height caused an unsurvivable right-sided subdural haemorrhage. He died at 14:26hrs on 22/10/18. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a. CATASTROPHIC HEAD INJURY 1b. FALL FROM HEIGHT 2. POLYTRAUMA
5	**<u>CORONER'S CONCERNS</u>** 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. Mr Watson was aged 72. The Community Mental Health Team advised on 18/10/18 that he required an immediate admission for inpatient mental health treatment for his own safety. However, this could not happen as no bed was available within the area. Three days later there was still no bed available. Mr Watson was not offered a bed out-of-area. 2. This report has similar themes to the 7 reports issued by the Birmingham and Solihull Coroners on 4/10/18. 3. However, the impact of Mr Watson's age is a new issue. 4. I heard evidence that: a. Younger and older adults will not normally be admitted as inpatients on mixed units. Beds on young adult units may have been available on 18-22 October 2018 but these were not considered. b. Beds in neighbouring areas are unavailable because of contractual issues. The closest out of area option is at least 70 miles away. Although Mr Watson was not offered an

	out of area bed, his wife was confident that had one been offered he would have declined because 70 miles was so far away. Whilst this distance is likely to deter a patient of any age from accepting the offer, it is particularly problematic for elderly patients and their families. c. Whilst remedial action is underway in response to the concerns raised in the 7 reports issued on 4/10/18, currently it still remains the position that at least one patient every day in Birmingham and Solihull is advised they require an immediate admission for inpatient mental health treatment but no bed is available within the area. 5. The lack of inpatient beds is a resource issue. My ongoing concerns are that (a) there are insufficient numbers of beds in Birmingham and Solihull, and (b) out-of-area beds are too far away.
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 April 2019. 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. [redacted] – Mr Watson's wife. 2. Birmingham and Solihull Mental Health NHS Foundation Trust. I have also sent a copy to the Care Quality Commission as it may be of interest or use to them. 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	12/02/2019 Signature  Mr James Bennett HM Assistant Coroner Birmingham and Solihull