	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: NHS England and Birmingham and Solihull Clinical Commissioning Group**
1	**CORONER** I am Emma Brown Area 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 18/05/2018 I commenced an investigation into the death of Bradley Jordache Morgan. The investigation concluded at the end of an inquest on 13th September 2018. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was declared dead at 10:13 on the 13th May 2018 as a result of falling from the 8th floor balcony of his home. The Deceased had a history of psychotic illness, depression and a grief reaction and was under the care of the community mental health team who last saw him in December 2017 at which time he was evidently at high risk of suicide and self harm. He was prescribed antidepressants and antipsychotics but urgent follow up was not arranged. He discontinued his medication in January 2018 without seeking medical advice until he was persuaded by his GP on the 6th March to seek a further appointment with the mental health team. An appointment with the community mental health team had coincidently been arranged for the 14th March after a waiting list audit but it is not known if he was aware as the address used for the appointment letter had not been confirmed to be his current address despite clinicians within the team knowing his housing situation was in flux at the time of his last appointment in December 2017. Mr. Morgan did not attend the appointment and no attempt was made to contact him contrary to Trust policy. It is not known what difference appropriate follow-up from mental health would have made. Mr. Morgan's family were aware that he was struggling and had tried to keep him safe such as locking the door to the balcony but he had removed safety chains from a nearby window to access the balcony on the day of his death. Following a post mortem the medical cause of death was determined to be: 1a MULTIPLE BLUNT INJURIES
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. Investigation into Mr. Morgan's mental health care provided by Forward Thinking Birmingham identified gross failings following an appointment on the 15th December 2017 where despite an obvious need for follow up there was a breakdown in communication between teams and individuals that meant he was not reviewed again before his death in May. 2. A detailed root cause analysis investigation had been undertaken by Birmingham Women's and Children's NHS Foundation Trust (who operate Forward Thinking Birmingham) resulting in a comprehensive action plan. 3. Despite the comprehensive action plan evidence was given by the Medical Director of the Birmingham Women's and Children's NHS Foundation Trust that she was concerned that even with the processes and training identified in the action plan similar circumstances could arise again due to the pressures placed on staff who carry caseloads well in excess of the national average as a result of demand on the service. 4. The evidence given was that chronic underfunding of mental health services is creating a risk to

	life. 5. The strain on the systems of Mental Health Services provided by both Forward Thinking Birmingham and Birmingham and Solihull Mental Health NHS Foundation Trust has become apparent to the Birmingham and Solihull Coroners in recent months. Consequently this report to prevent future death is being made in conjunction with reports to prevent future deaths arising from 6 other investigations into deaths between May and August 2018 that demonstrate a risk that future deaths will occur as a result of under-funding. 6. In addition to this report letters are enclosed from the Medical Directors of both Trusts setting out their concerns.
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 29th 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 the family of Mr. Bradley Morgan and Birmingham Women's and Children's NHS Foundation Trust. I have also sent a copy of this report to the Care Quality Commission and Birmingham and Solihull Mental Health NHS Foundation Trust. 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	04/10/2018 Signature  Emma Brown Area Coroner **Birmingham and Solihull**