	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 23rd August 2018 I commenced an investigation into the death of Stephen Peter Jackson and an inquest is listed to take place on the 4th December 2018.
4	**CIRCUMSTANCES OF THE DEATH** Investigations to date have identified that Mr. Jackson sent his mother a text message late evening on 10th August 2018 saying "sorry". His mother contacted Mr. Jackson's partner after several attempts to get hold of him were unsuccessful. His partner attended Mr. Jackson's home on the 11th August 2018 and found him deceased lying face upwards on the bedroom floor having entered via an unsecured bedroom window. Drugs paraphernalia was noted at the scene along with a suicide note. The Deceased had deliberately taken an overdose 3 weeks earlier and been admitted to Good Hope Hospital where he self-discharged once medically fit without waiting to be seen by the RAID team. Following discharge he sought a home treatment team input, he was given an outpatient appointment on the 13th August 2018 but the appointment was put back until the 29th November 2018. Evidence to date indicates that he was very frustrated by this delay and reported to family that he could not cope. Following a post mortem a provisional cause of death has been given as 1a) Diamorphine overdose but the final cause of death is awaited pending consideration of toxicology results.
5	**CORONER'S CONCERNS** During the course of the investigation to date the evidence has 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. On the 1st August 2018 Mr. Jackson attended his GP and expressed frustration that following his discharge from hospital on the 23rd July 2018. He had not been contacted by the home treatment team and his GP wrote to the Kingstanding and Erdington Home Treatment Team that same day asking them to expedite his appointment, reporting that Mr. Jackson continued to have low mood and negative thoughts and merited an urgent appointment. 2. Mr. Jackson was not seen by mental health clinicians following the GP request. 3. Mr. Jackson wrote a very detailed suicide note within which he refers to feeling unsupported by professionals who did not send him appointments or answers his calls, the context would support this being a reference to mental health professionals. 4. Although evidence at inquest has yet to be heard there is a concern that this case, along with several other cases being investigated by the Birmingham and Solihull Coroners' jurisdiction, future deaths may arise due to under-funding of mental health services. 5. The strain on the systems of mental health services provided by both Forward Thinking Birmingham and Birmingham and Solihull Mental Health 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: Mr. Jackson's next of kin and the Birmingham and Solihull Mental Health Trust. I have also sent it to Birmingham Women's and Children's NHS Foundation Trust and the Care Quality Commission who may find it useful or of interest. 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**