	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Birmingham and Solihull Mental Health NHS Foundation Trust • Secretary of State for Health • Birmingham Cross City Clinical Commissioning Group
1	**CORONER** I am Mrs Louise Hunt HM Senior 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 12/10/2018 I commenced an investigation into the death of Stephen Anthony Kennedy. The investigation concluded at the end of an inquest on 7th February 2019. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from emotional unstable personality disorder and depression. He had been under the care of the mental health team for several years. His condition resulted in frequent attempts to self harm which was managed through hospital admissions and at home with support from the home treatment team. His condition deteriorated during 2018. He was seen regularly by the mental health team with his last admission being from 22/08/18 until 11/09/18. He was then reviewed by the home treatment team. He presented to Good Hope Hospital on 07/10/18 with chest pains and low mood. He was assessed by a mental health nurse and arrangements were made for ongoing support from the home treatment team and to see his consultant on 08/10/18. He was found hanging from a door frame at his home address on 08/10/18 and was declared deceased at 10.07. During 2018 he did not receive any psychological therapy as recommended by NICE. Following a post mortem the medical cause of death was determined to be: 1a. HANGING
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. The deceased suffered from emotional unstable personality disorder and was in crisis for most of 2018. The recommended treatment for his condition was psychological therapy. He had not had any psychological input since 2010. The inquest heard that whilst he was under the care of the home treatment team there was no access to psychology services. He had to be under the community mental health team to be able to access psychological services. There were periods when he was under the care of the community mental health team but at this time he remained on a long waiting list for psychological services. Throughout 2018 he never received any psychological services. I am concerned that the main treatment option for the deceased was not available to him due to internal structures and long waiting lists. 2. In August 2018 the deceased required inpatient treatment. There were no beds available and as a result he had further episodes of self-harm and suicide attempts. The availability of acute beds is a serious concern.

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 5 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: Family I have also sent it to NHS England and CQC 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	07/02/2019 Signature  Mrs Louise Hunt **HM Senior Coroner** **Birmingham and Solihull**