	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 23/08/2018 I commenced an investigation into the death of William Peter Edge and an inquest is listed to take place on the 11th December 2018.
4	**CIRCUMSTANCES OF THE DEATH** Evidence obtained to date indicates that the deceased was found hanging in the shed in the back garden of his home address in the Quinton area of Birmingham on the 18th August 2018. He was found by his wife who took him down from the ligature and attempted to perform resuscitation and called an ambulance. An ambulance crew arrived and continued CPR before pronouncing life extinct after approximately 30 minutes at 15:48. The Deceased had a diagnosis of depression and a history of self-harm. On the 17th August 2018 the Deceased had attempted to hang himself but was discovered by his wife and taken to the Queen Elizabeth Hospital where he was assessed by the RAID team of the Birmingham and Solihull Mental Health NHS Foundation Trust. When he was physically fit he was released but RAID referred him to the home treatment team. Home treatment team attended the home address on the 18th August 2018 at 1300hrs and left a note due to no-one answering the door at deceased home address. The deceased wife has returned home at 1330hrs seen the note and searched for deceased leading to him being found deceased. Following a post mortem the medical cause of death was determined to be: 1a) HANGING 2) PRESENCE OF ETHANOL
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. It is the evidence [redacted] that the Deceased had stated to the RAID team on the 17th August 2018 that he wanted to be admitted and if he was discharged he would kill himself. He was discharged with a referral requesting the Home Treatment Team ('HTT') call him the next day. 2. When [redacted] returned home at about 13:30 she found the note from the HTT saying that they had visited but left when no response was obtained. She called the HTT and begged them to come back that day as she felt her husband was in imminent danger, they stated they could not return that day because they needed to see other patients. 3. The Coroner is aware, although not from evidence obtained in respect of Mr. Edge's case as the inquest is yet to take place, that inpatient beds within the BSMHFT are currently operating at 109% capacity and are often not available. Consequently patients who would otherwise have been offered in-patient treatment are having to be managed by the HTTs, partly as a consequence of this but partly due to other pressures the demand on the HTTs is often too great to enable them to visit all patients requiring a visit in any one day which in turn is putting pressure on out of hours services. It is understood that the Trust is exploring options to expand its HTT service but funding is required. 4. The fact that at the current time HTTs cannot attend patients when required creates a risk to life. 5. 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 may

	arise from underfunding of mental health services. 6. 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. 7. 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 next of kin of Mr. Edge and the Birmingham and Solihull Mental Health NHS Foundation 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**