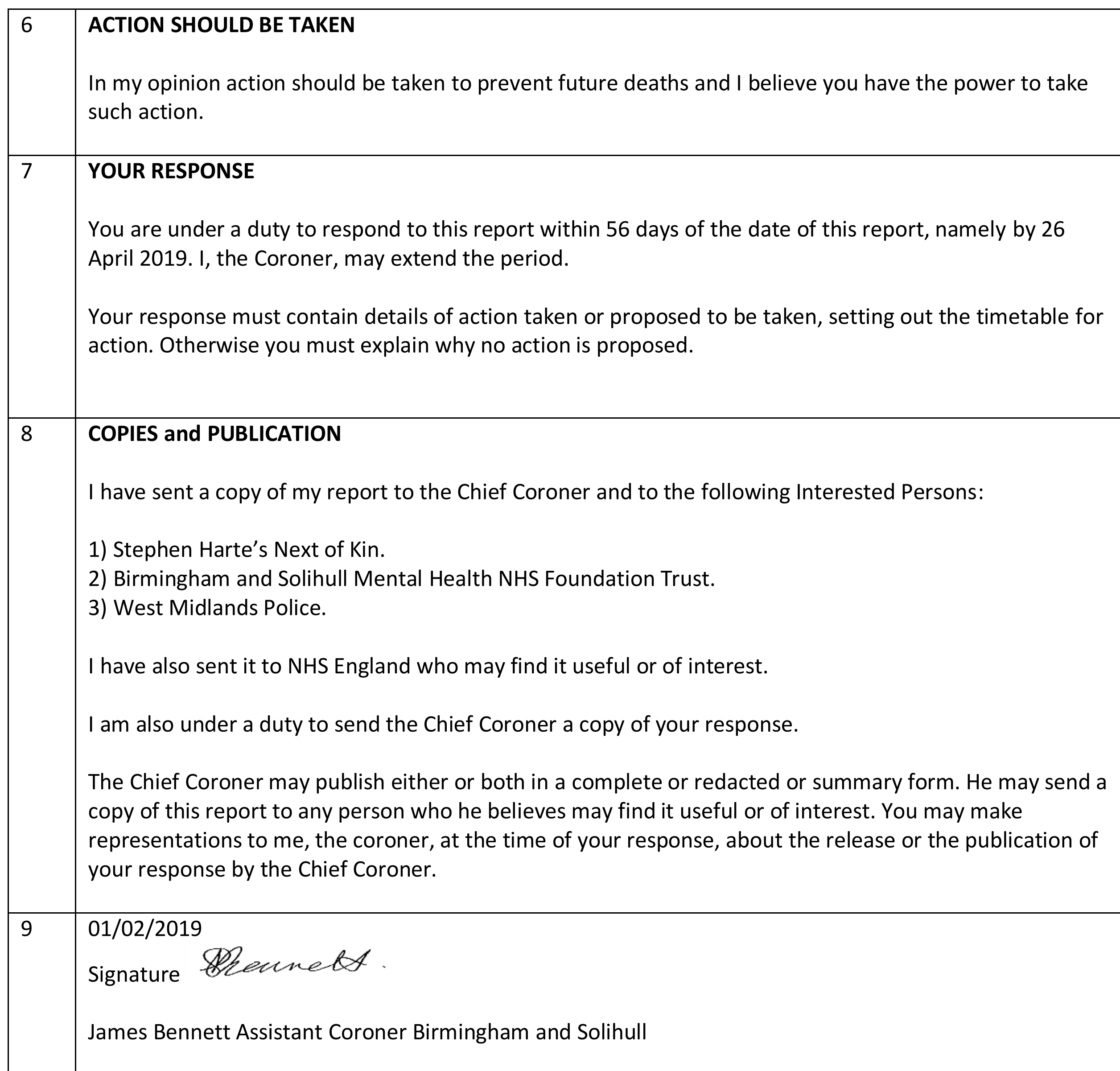
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1) Birmingham and Solihull Clinical Commissioning Group 2) Care Quality Commission
1	**CORONER** I am James Bennett Assistant Coroner for Birmingham and Solihull.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 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 04/09/2018 I commenced an investigation into the death of Stephen Keith Harte. The investigation concluded at the end of an Inquest with a jury on 13th February 2019. The jury's conclusion was the death was Drug Related.
4	**CIRCUMSTANCES OF THE DEATH** At 4.33hrs on 18/08/18 Stephen Harte was found unresponsive in his room at the Tamarind Centre (a medium secure mental health unit). Despite emergency medical treatment he could not be resuscitated, and he was pronounced deceased at the scene. A post-mortem blood test revealed he had taken a recognised fatal dose of heroin. Mr Harte had a long history of illicit drug use but appeared to have been abstinent since 2016. Following a post mortem the medical cause of death was determined to be: 1a. Heroin toxicity.
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) I heard evidence about the potential routes for drugs to enter the medium secure unit. This included: (a) Residents are allowed unsupervised telephone calls to order food from external 'takeaways' of their choice and the food is not searched upon arrival. Historically, residents were only allowed to order from an approved list of 'takeaways'. However, following a Care Quality Commission inspection the CQC deemed this was too restrictive and asked that the unit relax its rules. The evidence was unclear whether the CQC had similarly asked other units to relax their rules. (b) Those residents allowed unsupervised leave are not typically searched upon their return. They walk thought a scanner, but this is unlikely to reveal small quantities of drugs on their person. 2) The author of Birmingham and Solihull Mental Health Foundation NHS Trust's Root Cause Analysis report gave evidence that in his opinion these two routes were the most likely mechanism by which Stephen Harte obtained the drugs that killed him, and that the rules around 'takeaways' needed revisiting. 3) I also heard evidence that staff are not typically searched upon entering the unit. They also walk thought the scanner, but this is unlikely to reveal small quantities of drugs on their person. Further, whilst they are required to leave personal belongings in lockers, they are allowed to take their own food on to the unit which is also not searched. 4) My ongoing concern is that drugs can too easily enter the unit.



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 26 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) Stephen Harte's Next of Kin. 2) Birmingham and Solihull Mental Health NHS Foundation Trust. 3) West Midlands Police. I have also sent it to NHS England 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	01/02/2019 Signature James Bennett Assistant Coroner Birmingham and Solihull