


	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: Birmingham and Solihull Mental Health NHS Foundation Trust, NHS Birmingham and Solihull Clinical Commissioning Group</p>
1	<p>CORONER</p> <p>I am Emma Brown Area Coroner for Birmingham and Solihull</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 17/05/2019 I commenced an investigation into the death of Anthony Joseph McCormack. The investigation concluded at the end of an inquest on 27th August 2019. The conclusion of the inquest was Suicide due unavailability of an inpatient mental health bed.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>The Deceased was found dead at his home on the 7th May 2019 after family became concerned that he was not answering calls. The Deceased who suffered with paranoid schizophrenia had been identified as being in crisis on the 6th March 2019 and authorisation had been given to compel him to undergo inpatient treatment under section 2 of the Mental Health Act on the 16th March 2019. However, a bed was not available and he was managed by the home treatment team. The home treatment team were not in a position to adequately assess Mr. McCormack due to the nature of his underlying condition, this led to an underestimation of his risk and he was taken off the waiting list for a bed on the 25th April 2019 and discharged from the home treatment team to the community mental health team on the 29th April 2019. Mr. McCormack was not reviewed again by mental health services despite a request from his family on the 7th May because they were concerned for his wellbeing. If Mr. McCormack had been admitted to hospital it is likely that on the 7th May 2019 he would have remained in hospital receiving more effective treatment than in the community and would not have ended his life.</p> <p>Following a post mortem the Deceased's treating clinicians the medical cause of death was determined to be:</p> <p>1a) HANGING</p>
5	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none"> 1. Between the 16th March 2019 and the 25th April 2019, a bed could not be found for the Deceased even though he had been assessed and fit for detention. The absence of a bed meant that Mr. McCormack was not adequately assessed and appropriate treatment could not be given. With inpatient admission it is unlikely Mr. McCormack would have taken his life. The evidence from witnesses from BSMHT was that there continues to be a shortage of beds. 2. Evidence was given that the case load of the home treatment team to whom Mr. McCormack was referred is carrying 5 times the number of patients it was originally intended for and does not have the resources to provide adequate assessment and monitoring to patients thereby putting lives at risk.
6	<p>ACTION SHOULD BE TAKEN</p>

	<p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 22 November 2019. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Mr. McCormack's next of kin.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>27/09/2019</p> <p>Signature </p> <p>Emma Brown Area Coroner Birmingham and Solihull</p>