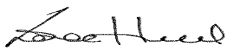
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Birmingham and Solihull Mental Health Trust**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 20/06/2018 I commenced an investigation into the death of Paul Price. The investigation concluded at the end of an inquest on 18th September 2018. The conclusion of the inquest was Open.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of depression and anxiety. He first exhibited suicidal ideation in March 2018. He was assessed by the mental health team. He had a full assessment by a consultant on 04/05/18 and was prescribed further medication. He presented to the emergency department at City Hospital on 15/05/18 having taken an overdose. He was then assessed by his GP on 16/05/18 when he denied any suicidal ideation and said his actions had been a cry for help. His GP spoke to him on 21/05/18 when he seemed better. On 01/06/18 the window in his room was found to be damaged and was repaired and closed. The mental health team were contacted as there were concerns about his wellbeing. The mental health team advised their systems were down and they would ring back however no one rang back. There were no concerns about him on 02/06/18 and 03/06/18. On 04/06/18 he was found on the ground outside his room having fallen from the window. His intentions at the time are unclear. He was taken to the Queen Elizabeth hospital where he was pronounced deceased at 13.06. Following a post mortem the medical cause of death was determined to be: MULTIPLE INJURIES
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. Paul was seen for a full assessment on 04/05/18. The summary of that attendance in a letter was not received by the GP until 29/05/18. In the meantime Paul had attended his GP with ongoing concerns about his mental health and requesting further medication. The delay in receiving critical information about vulnerable patients could put them a risk and result in over prescribing medication. In addition I was told that the IT systems for Birmingham and Solihull Mental Health Trust and the GPs are incompatible meaning that letters have to be faxed or posted causing further delay. 2. A call was made to the Mental Health team on 01/06/18 raising a concern about Paul's mental health. The caller was told that the computer systems were down and the mental health team would call back – they did not call back. There is concern that staff are not accurately recording information and arranging follow-up.

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 14th 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 family. I have also sent it to NHS England, CQC and the CCG 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	18/09/2018 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**