	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, Birmingham and Solihull Mental Health Foundation Trust
1	**CORONER** I am James Bennett, 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 August 2021 I commenced an investigation into the death of Natasha Mary ADAMS. The investigation concluded at the end of the inquest on 26 April 2022.
4	**CIRCUMSTANCES OF THE DEATH** Natasha had a history of depressive symptoms and deliberate overdoses and was under the care of the mental health community team. She was last reviewed on 2 July 2021 following an escalation in symptoms when it was recognised she had emotional dysregulation. She was treated with medication and was to be reviewed again in October 2021. Late on 11 August she self-presented at the emergency department at Queen Elizabeth Hospital reporting recent fleeting suicidal thoughts of taking an overdose. She was assessed by the psychiatric liaison team to be in crisis but reported no immediate plan to take her own life. The liaison nurses wanted Natasha to attend the psychiatric decision unit for further assessment, but she had capacity to choose to go home, knowing that she would be referred to the home treatment team. She was not in fact referred until the evening of 12 August due to an administrative issue. Had she been referred, it is likely she would have been telephoned on the morning of 12 August when still alive. At approximately 8.45pm on 12 August she was found by a neighbour at home [redacted]. She had left a note indicating her intention to end her own life. Following a post mortem the medical cause of death was determined to be: 1a Suspension by [redacted]. The conclusion was death was due to suicide.

	CORONER'S CONCERNS 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 **MATTER OF CONCERN** is as follows.
5	BSMHFT's Root Cause Analysis Report identified that in July 2021 Natasha's level of care level was downgraded from CPA to Care Support without clinicians following the trust's Care Management & CPA/Care Support Policy 2019. I heard evidence from Natasha's family this had a dramatic impact on Natasha's mental health. The RCA action plan identified the need to conduct an audit of other patients to check the trust's compliance with the Care Management & CPA/Care Support Policy 2019. The RCA Report was released in December 2021. The evidence was that 4 months later no action has been taken and other patients have not yet had their cases audited. The delay is the trust's Clinical Governance Committee needs to approve the audit process, which is unlikely to happen until the summer of 2022, and possibly not until as late as September 2022 because of staff holidays. In my view until such a delay is of serious concern and action should be taken to bring forward the audit.
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 22 June 2022. 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: [redacted], parents. 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	**27 April 2022** Signature:  **James Bennett** **Area Coroner for Birmingham and Solihull**