	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Birmingham and Solihull Mental Health NHS Foundation Trust**
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 08/10/2015 I commenced an investigation into the death of Luke Christie AYRES. The investigation concluded at the end of the inquest . The conclusion of the inquest was: "Luke was found unresponsive in his room around 7pm on 27 September 2015 with a ligature around his neck. Resuscitation was attempted but Luke could not be resuscitated." The medical cause of Luke's death was: 1(a) SUSPENSION BY A LIGATURE AROUND THE NECK
4	**CIRCUMSTANCES OF THE DEATH** Luke was 24 years old when he died on the 27th September 2015 at the time of his death he was serving a custodial sentence as an inpatient at Raeside Clinic under section 45(a) of the Mental Health Act. Luke was on the intensive care ward, ward Severn, on the 27th September 2015. At approaching about 18.55 a HCA noticed that Luke had covered his observation window in his bedroom door, this sparked a series of events that led to his door having to be opened with the anti-barricade system at about 19:00 when Luke was found hanging by a ligature made of a piece of cord placed over the top of the bedroom door. CPR was commenced and an ambulance crew arrived at Luke's side at about 19.09 but Luke could not be resuscitated. The case gave rise to issues surrounding the risk assessment of Luke, the operation of the anti-barricade system and the actions of staff from the point when they realised they couldn't get into Luke's room onwards.
5	**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 **MATTERS OF CONCERN** are as follows. – 1. The 999 call to the ambulance service made by Raeside reception after the issuing of a 2222 medical emergency call was cut off when they attempted to transfer the Ambulance Service to Ward Severn. The Ambulance Service therefore had to get the number from the operator and called back a minute later. When they were put through to the Ward the person they were speaking with was not at Luke's side and did not know his current status because she was in an office some distance away from him and the staff with him. There is no evidence that this actually had an impact on Luke's death but there are risks for the future arising from the fact that: a) the Ward staff do not call 999 themselves necessitating a delay and a risk of the call being cut off when the call is transferred to the Ward; and

	b) the person providing information to the Ambulance Service may not know the patient's current status and could therefore give incorrect information. 2. The evidence was that when the Paramedics arrived in reception no-one was present to escort them to the Ward and only once they had arrived did a member of staff go to meet them. This is a source of obvious and dangerous delay.

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 15 June 2016. 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 parents of Luke Ayres and their legal representatives. 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	15/04/2016 Signature  Emma Brown Area Coroner **Birmingham and Solihull**