	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Black Country Partnership 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 20th January 2016 I commenced an investigation into the death of Richard Paul Martin Grant. The investigation concluded at the end of the inquest 21st April 2016. The conclusion of the inquest was: "Suicide whilst awaiting an assessment for Counselling with Birmingham and Solihull Mental Health NHS Foundation Trust, this assessment had been delayed by something in the region of a month because the Black Country Partnership NHS Foundation Trust had not referred the Deceased promptly. " The medical cause of death was: 1(a) SUFFOCATION 1(b) INERT GAS INHALATION
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was found passed away in his car in his garage behind his home on the 7th January 2016 as a result of inhalation of helium gas. The Deceased had previously self-harmed and threatened suicide on the 5th December 2015 he had co-operated with mental health assessment by Black Country Partnership NHS Foundation Trust on that occasion and requested counselling. However, the referral for counselling was sent to the wrong team and this was not identified until the 4th January 2016 when the referral was sent to the Birmingham and Solihull Mental Health NHS Foundation Trust at which time Mr. Grant reported that he was well with no thoughts of self-harm but was happy to proceed with counselling. An appointment was arranged for 22nd February 2016. An opportunity was missed by the Black Country Partnership NHS Foundation Trust to provide earlier assessment for counselling to Mr. Grant.
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) Mental Health Nurse Catherine Collins of the Oak Unit Mental Health Liaison Team gave evidence that the referral to the Black Country Partnership Single Point of Referral ('SPOR') team was faxed on the 7th December 2015. Only when Mr. Grant chased with Oak Unit why he had not received an appointment or further contact from Mental Health Services on the 4th January 2016 was it identified that his referral ought to have been sent to the Birmingham and Solihull Mental Health NHS Foundation Trust single point of access team. Ms. Collins and the Black Country Partnership have provided no explanation for what happened to Mr. Grant's referral between it being sent on the 7th December and the 4th January 2016.

	A clear risk to life clearly arises from patients who have been referred because of suicide attempt not being referred to the right team within a reasonable time. (2) A letter detailing [redacted] assessment and the outcome of it was not sent to Mr. Grant's GP until at least the 22nd December 2015, [redacted] did not know why there was such a delay nor whether it was typical. There is a clear risk to life from GPs not being aware of the circumstances and outcome of assessments of patients who have attempted suicide for such an extended period.

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 16th 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 family of Mr. Grant and the Birmingham and Solihull Mental Health NHS Foundation Trust. 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	21st April 2016 Signature_____ Emma Brown Area Coroner **Birmingham and Solihull**