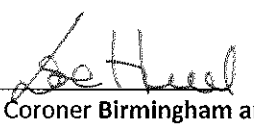
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Birmingham and Solihull Mental Health Trust** **2. NHS England** **3. Department of Health** **4. Care Quality Commission**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
2	**CORONER'S 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 31/03/2016 I commenced an investigation into the death of Patricia Ann Cleghorn. The investigation concluded at the end of the inquest 25th July 2016. The conclusion of the inquest was that the deceased died from an intentional overdose whilst being cared for in the community. She had been waiting for an in-patient mental health bed since 09/12/15. She was allowed to self-medicate drugs including amitriptyline and morphine despite repeatedly stating she would take her own life through an overdose. Her death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of low mood and depression following the death of her mother. At the time of her death she was under the care of the mental health home treatment team. A decision had been made for voluntary admission to hospital on 09/12/15 as she had suicidal ideation. As no beds were available she received twice daily visits from the home treatment team. She had stated several times that she intended to take her own life by an overdose. She was allowed to self-medicate her own medications which included amitriptyline and MST tablets and oromorph – both morphine medications. At 17.00 on 14/12/15 the deceased was seen at home in her bedroom by the home treatment team and give a 5mg diazepam tablet. This had a dramatic effect on her which was not appreciated by the healthcare assistant despite questioning by the deceased's husband. Soon after the deceased was found collapsed on the floor and an ambulance was called but the deceased was declared dead by paramedics.
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) The deceased could not be admitted to hospital as there were no inpatient beds available. I heard evidence at the inquest that had she been admitted it is unlikely she would have died when she did. The

	availability of acute mental health beds means the most vulnerable people are being cared for in the community with limited resources and care. (2) The deceased had repeatedly stated that she would end her life by taking an overdose. Despite this she was left at home self-medicating drugs including amitriptyline, MST and oramoprh. No formal risk assessment was undertaken and staff failed to appreciate what drugs she had available to her.
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 Tuesday 20 September 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 [redacted] 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	25/07/2016 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**