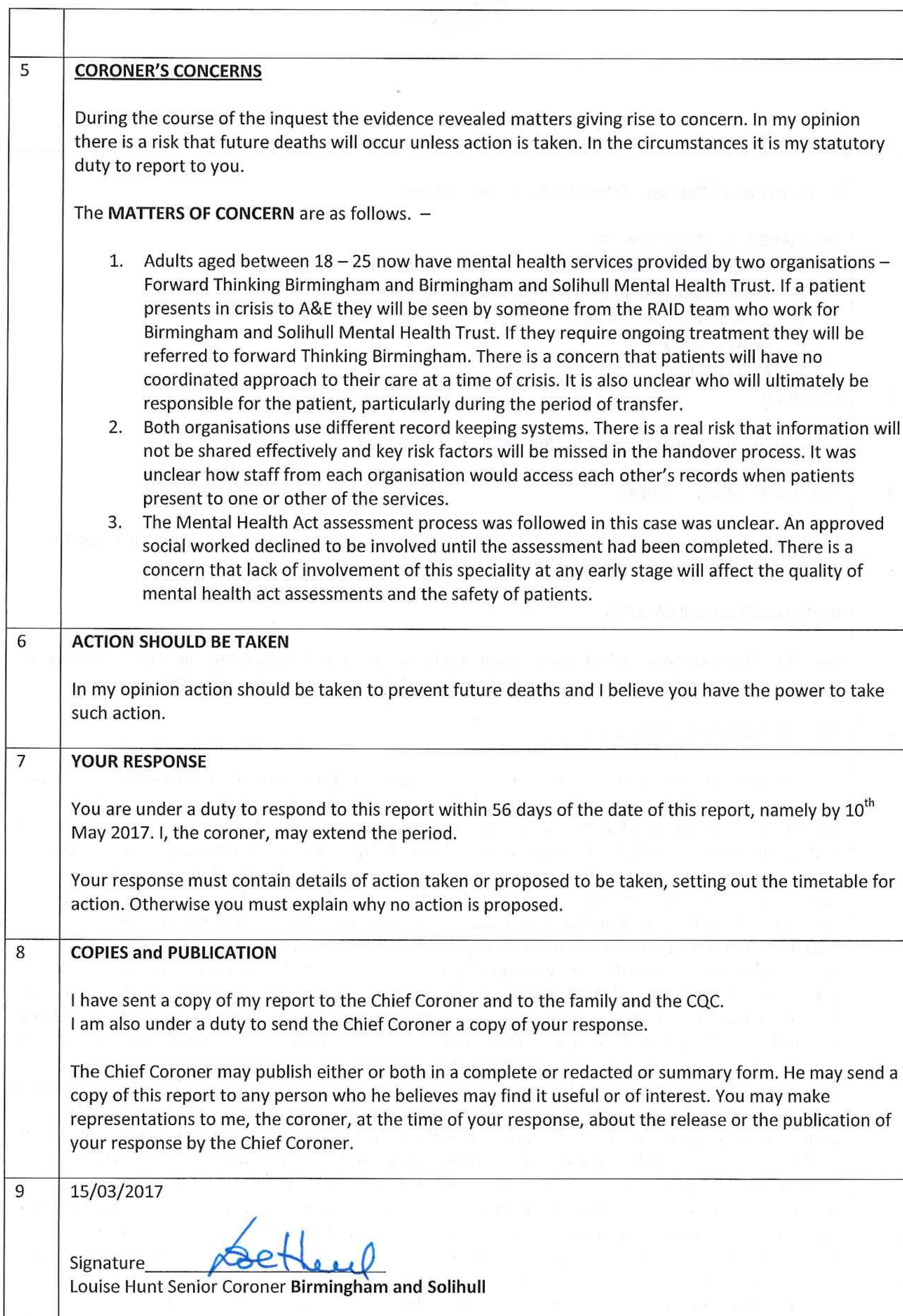
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Birmingham Children's Hospital NHS Foundation Trust** 2. **Birmingham and Solihull Mental Health Trust** 3. **Birmingham City Council** 4. **Cross City CCG** 5. **NHS England**
1	**CORONER** I am Louise Hunt Senior Coroner 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 13/10/2016 I commenced an investigation into the death of Leah Abby Ratheram. The investigation concluded at the end of an inquest on 13th March 2017. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was known to suffer from autism (Asperger's syndrome) and foetal alcohol syndrome and resided in supportive living accommodation. She was vulnerable and had previous episodes of self-harm and had been the subject of an assault in February 2016 and had previously been treated by Birmingham and Solihull Mental Health Trust. She presented at A&E at University Hospital Birmingham on 13/09/16 having taken and overdose of 48 paracetamol tablets. She was referred to the RAID team where she was assessed by a nurse at 16.40 and subsequently by a doctor who discharged her with lorazepam and further care from Forward Thinking Birmingham (FTB) home treatment team. FTB took over responsibility for the deceased's care on 30/09/16. There was no formal handover to this new organization. On 02/10/16 the deceased put a ligature around her neck which was removed by staff where she was living. On 03/10/16 staff contacted the community mental health team at Warstock Lane but were advised care had been transferred to FTB. 04/10/16 she attempted to hang herself at the home where she was living. Initial attempts to contact FTB were unsuccessful. At 19.30 staff spoke to FTB who advised for the deceased to be taken to A&E at University Hospital Birmingham. She was assessed by RAID and sent home with further follow up from the FTB crisis team. She was on 15 minutes observations at the home who communicated that they were unable to manage this degree of risk. On 05/10/16 numerous attempts were made by the home to contact FTB. She was assessed by the crisis team at 16.00 on 05/10/16 who advised a further assessment by an approved mental health practitioner. This assessment was undertaken at 22.30 which discussed hospital admission. The deceased was reluctant to be admitted to hospital and it was agreed she would be treated at home and reviewed the following day by a doctor with the home manager present. This did not occur. The crisis team attended the home at 17.30 on 06/10/16 to find the deceased had not returned from a shopping trip as expected at 17.00. The deceased was reported as missing. At 11.35 on 07/10/16 the deceased was found hanging from a tree branch in woodland close to Stratford Canal, Yardley Wood Road. She was declared deceased by paramedics. She had previously purchased 2 locks and a chain from a hardware store at 16.00 on 06/10/16. Following a post mortem the medical cause of death was determined to be: HANGING



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. Adults aged between 18 – 25 now have mental health services provided by two organisations – Forward Thinking Birmingham and Birmingham and Solihull Mental Health Trust. If a patient presents in crisis to A&E they will be seen by someone from the RAID team who work for Birmingham and Solihull Mental Health Trust. If they require ongoing treatment they will be referred to forward Thinking Birmingham. There is a concern that patients will have no coordinated approach to their care at a time of crisis. It is also unclear who will ultimately be responsible for the patient, particularly during the period of transfer.
2. Both organisations use different record keeping systems. There is a real risk that information will not be shared effectively and key risk factors will be missed in the handover process. It was unclear how staff from each organisation would access each other's records when patients present to one or other of the services.
3. The Mental Health Act assessment process was followed in this case was unclear. An approved social worked declined to be involved until the assessment had been completed. There is a concern that lack of involvement of this speciality at any early stage will affect the quality of mental health act assessments and the safety of patients.

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 10th May 2017. 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 and the CQC.
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 15/03/2017

Signature__________
Louise Hunt Senior Coroner **Birmingham and Solihull**