	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Northern Health and Social Care 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 23/05/2017 I commenced an investigation into the death of Conall Patrick Gould. The investigation concluded at the end of an inquest on 26th September 2017. The conclusion of the inquest was that Mr. Gould's death was drug related.
4	**CIRCUMSTANCES OF THE DEATH** Conall Patrick Gould died on the 13th February 2017 at the Queen Elizabeth Hospital in Birmingham having been admitted earlier that day after being witnessed to behave erratically and then collapse. Conall had a diagnosis of a delusional disorder, for which he had received inpatient treatment, and a history of drug. When last reviewed prior to discharge from inpatient psychiatric care at Holywell Hospital on the 30th January 2017 he had maintained a positive outlook and insisted that his most recent overdose was recreational and without any intention to cause himself harm. Following his discharge his behaviour did not give his family cause for concern that he would attempt suicide. Following a post mortem the medical cause of death was determined to be: 1 (a) ECSTACY USE
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. At the time of discharge from Holywell Hospital on the 30th January 2017 Mr. Gould had been referred to the community mental health team for a 7 day review and had been given an appointment on the 2nd February 2017. There is no evidence in the Trust's records that the time, date and location of this appointment was given to Conall or his parents. 2. The evidence of [redacted] Consultant Psychiatrist, who saw Conall and his father on the 30th January 2017 was that he anticipated that the discharge nurse would tell Conall and his mother or father, as his carers, the date of his review at the point of discharge as this is the usual practice. 3. Mr. Gould, Conall's father, gave evidence that not only were he and his wife not told verbally of the appointment nor were they given any written information about it: on a previous discharge from an inpatient stay at another Trust [redacted] had been given a letter setting out the appointment arrangements for his son following discharge. Conall was 21 at the time of his discharge on the 30th January and his parents had taken a very active role in his care. If they had been aware of the appointment they would have made every effort to secure Conall's attendance, as it was, believing there to be no plan for follow up, they did not prevent him from

	travelling to Birmingham for a period of rest with relatives (during which time he took the fatal overdose of MDMA). 4. The evidence of [redacted] who conducted the RCA was that the Trust does not have a protocol or policy stipulating the arrangements for notifying services users and their carers of follow up arrangements on discharge and current practice does not require written confirmation of follow up arrangements to be given to the service user or their carers. 5. The system currently creates a risk that services users and their carers will not be aware of follow up appointments and therefore may not attend giving rise to a danger that opportunities to review the service user's condition and treatment will be lost.
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 23rd November 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 following Interested Persons: [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	28/09/2017 Signature__________________ Emma Brown Area Coroner **Birmingham and Solihull**