	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: NHS England and Birmingham and Solihull Clinical Commissioning Group**
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 21/08/2018 I commenced an investigation into the death of Claire Michelle Ryder and an inquest is listed to take place on the 18th December 2018.
4	**CIRCUMSTANCES OF THE DEATH** The evidence collected to date indicates that Deceased was suffering with recurrent depressive disorder with severe psychotic symptoms for which she was being treated by Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) on the care programme approach ('CPA') with a care coordinator. The Deceased had a history of serious self-harm requiring hospital admission in January 2018. In early August 2018 Mrs. Ryder's husband had noticed a change in her behaviour and became concerned that her mental health was deteriorating and that she was suicidal when he found her at a railway station for no reason. Consequently [redacted] called the Lyndon clinic on the 6th August 2018 request an urgent visit but was told that an urgent visit could not be arranged and Mrs. Ryder would be seen at a pre-planned outpatient appointment the following week. On the 10th August 2018 Mrs. Ryder's husband was contacted by her care co-ordinator and made aware that Mrs. Ryder had not attended for her depot antipsychotic injection, consequently the care coordinator made a plan to see the deceased on the 13th August. On the 12th August 2018 [redacted] found Mrs. Ryder, deceased, hanging from the loft ladders at their home. Following a post mortem the medical cause of death was determined to be: 1a) HANGING
5	**<u>CORONER'S CONCERNS</u>** During the course of the investigation to date, the evidence has 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. A patient with a history of depression, psychosis and serious self-harm (resulting in patient treatment) was not seen within a working week despite her husband raising concerns that her condition had deteriorated and she was suicidal. 2. An urgent review of a patient with depression, psychosis and serious self-harm, who had not attended for her anti-psychotic medication injection and whose husband had raised serious concerns was not arranged over a weekend. 3. The Coroner is concerned that the delays in reviewing Mrs. Ryder may, at least in part, be attributable to resource issues. 4. Although evidence at inquest has yet to be heard there is a concern that this case, along with several other cases being investigated by the Birmingham and Solihull Coroners' jurisdiction may arise from underfunding of mental health services. 5. The strain on the systems of mental health services provided by both Forward Thinking Birmingham and Birmingham and Solihull Mental Health NHS Foundation Trust has become apparent to the Birmingham and Solihull Coroners in recent months. Consequently this report to prevent future death is being made in conjunction with reports to prevent future deaths arising from 6 other investigations into deaths between May and August 2018 that demonstrate a risk that future deaths will occur as a result of under-funding.

	6. In addition to this report letters are enclosed from the Medical Directors of both Trusts setting out their concerns.
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 29th November 2018. 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: Mrs. Ryder's next of kin and the Birmingham and Solihull Mental Health Trust. I have also sent it to Birmingham Women's and Children's NHS Foundation Trust and the Care Quality Commission who may find it useful or of interest. 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	04/10/2018 Signature  Emma Brown Area Coroner **Birmingham and Solihull**