	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 28/06/2018 I commenced an investigation into the death of Michael William Cooper. The investigation concluded at the end of an inquest on 26th September 2018. The conclusion of the inquest was Suicide contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was found dead as result of a ligature around the neck at his home address on the 22nd June 2018. He had been assessed by a psychiatrist on the 22nd May 2018 when it was evident he was at high risk of suicide and a plan was made for close follow up but he was not reviewed face to face thereafter despite a medication change. He had telephone contact with his care coordinator on the 7th June when his comments and situation indicated a high risk of suicide and no immediate action was taken. The absence of continued support and monitoring after the 22nd May will have caused a deterioration in Mr. Cooper's mental health contributing to his suicide. Following a post mortem the medical cause of death was determined to be: 1a) CONSTRICTION BY LIGATURE AROUND THE NECK
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. The Home Treatment Team advised on the 13th March 2018 that Mr. Cooper should be admitted for inpatient mental health treatment. However, this could not happen on the day as there was no bed available. The lack of inpatient beds is a known resource issue within the Birmingham and Solihull Mental Health NHS Foundation Trust, which the Trust is currently working to address through numerous new initiatives. In the absence of an inpatient bed, Mr. Cooper was managed with medication and home treatment team visiting twice a day. Whilst awaiting admission, he was offered an out-of-area bed on the 16th March 2018 but he declined this as he felt it would be detrimental to him to be so far from his wife and family. The Coroner is aware, although this was not an issue that came out in evidence in this case, that placing patients in out of area beds not only causes difficulty for maintaining the patient's support and visits from family and friends which can be prejudicial to their mental health, but also affects their continuity of care thus creating a risk to life. 2. An appointment following referral onto the Care Programme Approach on the 18th April 2018 was outside the two week timeframe specified in the Care Programme Approach Policy. This was due to capacity issues within the team and was not an isolated occurrence. Consequently a patient requiring follow up within 2 weeks may be left unsupported which creates a risk to life. 3. When Mr. Cooper was established on the Care Programme Approach, his Care Co-ordinator did not have the capacity to review his notes prior to her first visit and therefore did not have a clear understanding of his complex history. Care Co-ordinators within Birmingham and Solihull Mental Health Trust are currently carrying a caseload of more than 30 patients. The NICE guidelines for the Care Programme Approach advises that a Care Coordinator should have

	caseload of 15 patients. Without the time to familiarise themselves with their patients' histories Care Co-ordinators cannot make informed assessments of their risk which puts lives at risk. 4. Despite a detailed root cause analysis investigation with a comprehensive action plan arising from Mr. Cooper's case, without increased funding similar circumstances could arise again due to the pressures placed on staff and resources arising from demand for the service. 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 the family of Mr. Cooper and Birmingham and Solihull Mental Health NHS Foundation Trust. I have also sent a copy of this report to the Birmingham Women's and Children's NHS Foundation Trust and the Care Quality Commission. 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**