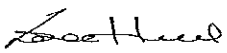
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: NHS England and Birmingham and Solihull Clinical Commissioning Group**
1	**CORONER** I am Emma Brown Area Coroner for **Birmingham and Solihull**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 2nd August 2018 I commenced an investigation into the death of Michael Paul Wheeler and an inquest is listed to take place on the 7th December 2018.
4	**CIRCUMSTANCES OF THE DEATH** Mr. Wheeler died as a result of jumping from a fourth floor window at the home of his brother with whom he was staying on the 26th July 2018. Mr. Wheeler had attended the Queen Elizabeth Hospital Birmingham on the 24th July 2018 because he was demonstrating extreme paranoia. He was concerned for his own safety and that of family members to the extent that he was trying to stop family members from leaving the house and had called the police to report that people were coming to attack him when there was no basis for this belief. Mr. Wheeler was seen by a psychiatric nurse from the Birmingham and Solihull RAID team whilst in hospital to who family reported an increase in bizarre behaviour in the last 8 to 9 weeks, including Mr. Wheeler isolating himself and becoming increasingly paranoid. Mr. Wheeler told RAID he would keep himself safe but it was identified by the nurse that he had limited understanding of his circumstances due to his paranoia. The RAID clinician concluded he could be discharged that day but needed to be seen urgently and referred him to the Home Treatment Team ('HTT') for a review the following day. Mr. Wheeler was visited the following day, the 25th July 2018, by a community psychiatric nurse from the HTT and it was identified that he required a medical review. This was booked for 10am on the 27th July 2018. Following a post mortem the medical cause of death was determined to be: 1a) Multiple Injuries
5	**CORONER'S CONCERNS** 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. Mr. Wheeler's family have provided evidence that he was extremely paranoid by the 24th of July 2018 and this was causing him to act irrationally and at times aggressively, they were very fearful for his safety and reported this to the mental health nurses he saw on the 24th and 25th. Despite these concerns Mr. Wheeler was not reviewed by a Psychiatrist and therefore his condition went undiagnosed with no treatment plan. Furthermore it is noted that there was no plan to review Mr. Wheeler at all on the 26th July 2018. 2. The Coroner is aware, although not from evidence obtained in respect of Mr. Wheeler's case as the inquest is yet to take place, that inpatient beds within the BSMHFT are currently operating at 109% capacity and are often not available. Consequently, patients who would otherwise have been offered in-patient treatment, are having to be managed by the HTTs. Partly as a consequence of this but partly due to other pressures the demand on the HTTs is often too great to enable them to visit all patients requiring a visit in any one day. One particular problem in the Birmingham and Solihull area is that the occurrence of psychosis is more than 3 times higher than the national average. It is understood that the Trust is exploring options to expand its HTT service but funding is required. 3. The fact that at the current time HTT cannot always provide urgent medical review by a psychiatrist creates a risk to life. 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: the next of kin of [redacted] 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  Louise Hunt, Senior Coroner **Birmingham and Solihull**