	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) NHS England 2) Birmingham and Solihull Clinical Commissioning Group 3) Future Care & Social Care Association
1	**CORONER** I am James Bennett Assistant 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 15 May 2018 I commenced an investigation into the death of Simon Anthony Graham. The investigation concluded at the end of an inquest on 28th September 2018. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was diagnosed with depression in 2015 which was later linked to excessive alcohol consumption. On 28 April 2018 he attempted to take his own life via an overdose and was admitted to hospital. Once physically recovered, mental health Drs and nurses concluded there was no imminent risk of suicide, and deemed it appropriate to discharge him to a respite home at 155 College Road with support from the home treatment team. On the day of arrival 3 May 2018 a mental health nurse concluded that there was no need to change his level of support, advised him of how to contact mental health services if necessary, and agreed to visit him again on 5 May 2018. On 4 May 2018 a support worker completed a risk assessment, to which the deceased contributed, and assessed the current risk of suicide as low. The deceased and his wife then had an uneventful and pleasant day out during which he consumed a moderate degree of alcohol. Shortly after his wife left him at the respite centre he text her 'bye' and she alerted a support worker via telephone at 19.26hrs. A combination of the support worker working alone, and the deceased's room key being incorrectly labelled, meant there was a delay of between 25-32 minutes before the door was forced open. This also caused a delay in telephoning 999. The deceased was discovered hanging from a ligature made from a curtain attached to a pole and in cardio-respiratory arrest. The support worker commenced CPR but had to break off for about 80 seconds, again as a consequence of working alone, to answer the door thinking it was the ambulance. CPR was re-commenced and later taken over by paramedics without success and death was confirmed at 20.44hrs. It is impossible to say precisely when the deceased tied the ligature and what if any impact the delay in entering his room had. Following a post mortem the medical cause of death was determined to be: 1a) SUSPENSION BY A LIGATURE AROUND THE NECK
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. Future Care & Social Care Association are a private company that own and run 7 respite homes and secure contracts with the NHS. All referrals come from Birmingham and Solihull Mental Health Trust and Forward Thinking Birmingham. 155 College Road only accommodates mental health patients some of whom will be in or recently out of mental health crisis. 2. Concern 1: At any one time only one support worker is working. The death of Simon Graham

	identified a number of concerns arising from lone working during an emergency: A) Upon concern being raised by Simon Graham's wife, the support worker was prevented from promptly checking on his wellbeing because he was with another resident at the medicine cupboard. He had to finish with the other resident and ensure the medicine cupboard was left secure. This caused a delay of about 10-15 minutes before the support worker could check on Simon Graham. Further delay was then caused by confusion over rooms – see below. B) After forcing entry and finding Simon Graham hanging and in cardiac arrest the support worker got him down and commenced CPR. He had to call for help from other residents but no one came. He had to break-off CPR for at least 80 seconds when he ran down three flights of stairs to answer the door thinking it was an ambulance (it was in fact the deceased's wife). I heard evidence that lone working still exists because the current financial contract with the NHS is insufficient to cover the cost of a second support worker, despite Future Care & Social Care Association wanting to end lone working. 3. Concern 2: Support workers were using keys to check on residents in their rooms knowing that they were labelled incorrectly. The fact Simon Graham's room key was incorrectly labelled added to the delayed entry to the room and emergency first aid. I heard evidence that after the death of Simon Graham all keys were checked to ensure they were labelled correctly. However, Future Care & Social Care Association want to implement a key fob system, to avoid any confusion and provide quick access in an emergency, but this has still not been implemented. Further funding would be required to implement a key fob system. 4. Concern 3: When a new patient arrives an unqualified support worker completes a suicide risk assessment based on a) the written observations/risk assessment from mental health Drs/nurses faxed over with the referral and b) talking directly to the resident about their intentions. There is no score system or guide to assist support workers. The support worker who completed the risk assessment for Simon Graham was unable to explain what makes him competent to undertake such an assessment and said in terms that he believes they should be undertaken by a mental health nurse. I heard evidence that unqualified support workers are continuing to undertake suicide risk assessments. 5. Concern 4: Future Care & Social Care Association have identified that support workers should undertake suicide prevention training. I heard evidence that some support workers have still not undertaken this training despite lone working and support workers continuing to undertake suicide risk assessments. 6. 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. 7. 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: 1) Chief Coroner 2) Next of kin (an Interested Person). 3) Birmingham & Solihull Mental Health NHS Foundation Trust (an Interested Person). 4) Care Quality Commission. 5) Birmingham Women's and Children's NHS Foundation Trust. 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	03/10/2018 Signature Bennett. James Bennett Assistant Coroner **Birmingham and Solihull**