	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) CHIEF EXECUTIVE OF BIRMINGHAM & SOLIHULL MENTAL HEALTH FOUNDATION TRUST**
1	**CORONER** I am Adam Hodson 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 17/01/2019 I commenced an investigation into the death of Nora Theresa Bruton. The investigation concluded at the end of an inquest on 22nd March 2019. The conclusion of the inquest was a narrative conclusion as follows: Death was by drowning whilst under the influence of alcohol. It was not known how the deceased came to be in the water, nor was it known what her intention was when she entered. Her mental health had declined, which was contributed to by gaps in her care, but it was likely her death could not have been prevented. The medical cause of death was: 1a) DROWNING 1b) ALCOHOL INTOXICATION
4	**CIRCUMSTANCES OF THE DEATH** On 15/11/2018, Nora Bruton was found face down in a pond in Babbs Mill Park, Kinghurst, Birmingham by a member of the public who summoned the emergency services, but who subsequently declared her deceased at the scene. Post-mortem and toxicological evidence indicate that her death was from drowning, and that she was under the influence of alcohol at the time of her death. The deceased had a long-standing history of alcohol dependence syndrome and mixed anxiety and depressive disease and was under the care of mental health services. The evidence indicates that there was insufficient assessment and formulation around the impact of increased alcohol on her suicidal thinking and risk to self, as well as there being other contributory factors such as lack of referral to Addiction Services and a lack of communication and accurate recording of crisis calls between the Home Treatment Team and the Community Mental Health Team..
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. A recommendation contained within the RCA report to carry out a review of the Clinical Risk Assessment training to incorporate clear risk formulation and management around harmful substance abuse, had been carried out, but this has had not been adequately disseminated to clinicians on the ground. Consideration therefore should be given to ensuring proper dissemination of this revised training to all treating clinicians as a matter of urgency; 2. A review of the protocol for communicating crisis calls to all teams involved in care delivery to ensure a robust system of communication has not been acted upon. I heard evidence that prior to Nora's death there had been two separate incidents which led to significant patient harm and/or death which involved gaps in crisis call communication. Consideration should be given to ensuring this review takes place and the protocol appropriately modified as a matter of urgency;

	3. I heard evidence that the Home Treatment Team model was undergoing a process of review and overhaul, and that this process had taken approximately 18 months to date but there was no estimate of when this would be completed by. Consideration should therefore be given as to ensuring that this review is concluded as a matter of urgency and any changes to the Home Treatment Team model are implemented with similar urgency.
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 20th May 2019. 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: 1) Next of Kin / family 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	25/03/2019 Signature  Adam Hodson Assistant Coroner **Birmingham and Solihull**