	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Birmingham and Solihull Mental Health Foundation Trust ('BSMHT'), Black Country Partnership Foundation Trust ('BCPFT'), West Midlands Police, NHS Birmingham and Solihull Clinical Commissioning Group and NHS England.**
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 15/10/2018 I commenced an investigation into the death of David Jonothan Jukes. The investigation concluded at the end of an inquest on 11th July 2019. The conclusion of the inquest was Mr. Jukes' death was a result of suicide. Despite being open to a Home Treatment Team ('HTT') and the Complex Treatment Service ('CTS') within Birmingham and Solihull Mental Health Trust ('BSMHT') Mr. Jukes had not undergone an adequate assessment of his mental health by the time of his death as a result of the following: i. At the time of attendance by the Liaison and Diversion practitioner at Oldbury custody suite on the 28th September 2018, the practitioner did not have full details of the events during the evening of the 27th into 28th from West Midlands Police nor access to records pertaining to his mental health held by his GP, the West Midlands Transition, Intervention and Liaison Service and BSMHT. With access to this information, she would have requested a Mental Health Act Assessment. ii. A Psychiatrist did not attend to assess Mr. Jukes whilst he was in custody on 28th September 2019 contrary to normal HTT practice. iii. Clinicians within HTT did not make adequate attempts to locate and engage with Mr. Jukes after being made aware of the events of the 27th and 28th September 2018 and after it was reported that he was threatening harm to others and to himself in a conversation with a psychologist on the 2nd October 2018. iv. Clinicians within HTT did not make adequate attempts to locate and engage with Mr. Jukes after he failed to attend for medical review on the 4th October 2018; v. Clinicians within HTT did not offer Mr. Jukes' an urgent medical review when they spoke to him on the morning of the 9th October 2018. It is possible that a full assessment would have prevented Mr. Jukes' death on the 9th October 2018 but it cannot be said that it would have been likely to prevent his death as it is not known what the outcome of such an assessment would have been nor to what extent any treatment following assessment would have been effective given the complex nature of his chronic condition, his alcohol and drug use and his hostility to mental health care providers.
4	**CIRCUMSTANCES OF THE DEATH** On the 9th October 2018 at 15:09 Mr. Jukes was declared deceased by paramedics in the back garden of 179 Ridgacre Road, Quinton. Due to childhood trauma and experiences in the armed forces, Mr. Jukes had been battling with mental illness for a long time; he abused illegal drugs and alcohol as a way of managing his condition. In around 2006 he was diagnosed with post traumatic stress disorder and was detained under the Mental Health Act for a brief period. He attempted to hang himself in 2016. In July 2018 he self-referred to the NHS West Midlands' Transition, Intervention and Liaison Services ('TILS'). Following an assessment by TILS on the 31st August 2018 he was referred to the Complex Treatment Service ('CTS'), a new team within Birmingham and Solihull Mental Health Trust ('BSMHT') providing NHS care specifically for veterans. Unfortunately the service was not to be fully operational in the West Midlands until the end of September 2018 and therefore there was a delay in contacting him. During this period Mr. Jukes' condition markedly deteriorated with he and his wife identifying that he was losing control during the weekend of the 15th September 2018 culminating in him taking an excess dose of his sleeping medication on Monday the 17th September 2018. Consequently he was referred to the Home Treatment Team ('HTT') within BSMHT. He was reviewed by CPNs at home on the 19th and 21st September at which

	time he did engage with services although showing resistance and was booked for a medical assessment. Despite attendances on the 24th and 27th September 2018 for medical assessment with a psychiatrist the assessment could not be completed because he was too difficult to assess, principally as a result of his profound mistrust of, and hostility towards, mental health services thought to derive from the failure of previous treatment. It was felt that his immediate risk of suicide and self harm was low. However, during the evening of the 27th September 2018 he became extremely agitated and aggressive with his family ultimately barricading himself in his loft and threatening suicide and harm to anyone who tried to come in. Police negotiators attempted to coax Mr. Jukes out of the loft but after several hours it was deemed best to leave him. He was arrested on suspicion of assault during this incident after coming down from the loft on the 28th September 2018. Whilst at Oldbury custody suite awaiting interview a health care practitioner and a community psychiatric nurse from the police liaison and diversion service were asked to review him; he did not engage with assessment but displayed no immediate risk to self. He initially returned to the family home following his release without charge from custody on the 28th but then left during the afternoon of the 29th September 2018. On the 2nd October he was contacted by the CTS psychologist. During this 20 minute phone-call the psychologist became extremely concerned about Mr. Jukes who was making threats against HTT and was indicating he had the means and a plan to end his own life. However, he would not disclose where he was. The Psychologist informed HTT with the hope that they would attempt to contact Mr. Jukes. HTT did not attempt to contact Mr. Jukes or his wife but decided to await a pre-planned medical review on the 4th October 2019. He did not attend that review and there is a record of a single unanswered call by HTT to contact him but it appears this was actually to his wife's phone by mistake. The CTS psychologist called his mobile phone twice on the 4th October 2018 but the calls went to voicemail. She reported her concerns for him to West Midlands Police on the 5th October 2018 but as his location was unknown there was nothing the police could do at that time. Mr. Jukes was seen to return to the vicinity of [redacted] on the 7th October 2018 and the police were informed of his presence but no unit was available to attend during the next 48 hours. An attempt to contact HTT was also made by Mr. Jukes' wife on the 8th October 2018 with the intention of making them aware of his location but the team did not return the call. On the morning of the 9th October 2018 a HTT nurse spoke to Mr. Jukes on the phone to invite him to a medical review, it was suspected that he was intoxicated, he disclosed no immediate concerns and stated he would attend an appointment on the 12th October 2018. He told the nurse he was back at [redacted] There was no attempt to arrange a review of Mr. Jukes sooner. At 10:23 on the 9th October, Police officers attended [redacted] in response to a call from his wife that Mr. Jukes was at the address and needed to leave because a non-molestation order was being obtained. He was found sat in the rear garden; he told the officers he would charge his phone in the shed and go - he gave the officers no cause for concern and no grounds to remove him from the property. However, when court bailiffs attended to serve the non-molestation order later that day Mr. Jukes was found hanging from a ligature fixed to the garden gate. Post mortem testing has shown that Mr. Jukes was not under the influence of alcohol or drugs at the time of his death. Following a post mortem the medical cause of death was determined to be: 1 a) HANGING
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. The psychiatric liaison and diversion practitioner employed by BCPFT who attended to review Mr. Jukes in Oldbury custody suite on the 28th September 2018 did not have sufficient information about the history of arrest to inform her decision making on assessment in custody. She was provided with a print out of the first two pages of the custody record which included the statutory arrest reason and the circumstances of arrest but nothing that indicated that he had barricaded himself in the loft, threated suicide and harm to others and not come out in

response to police negotiators. This information was not included in a verbal handover according to the nurse's evidence and there is no record of it being handed over to her. She stated in evidence that if she had been aware of the extent of the events overnight on the 27th into the 28th she would have arranged a Mental Health Act assessment when he did not engage with her. There is a risk to life if assessments of mental health in custody are not informed by material information about circumstances connected with arrest.

2. The above psychiatric liaison and diversion practitioner gave evidence that she contacted either the duty bed manager for BSMHT or the BSMHT liaison and diversion team based at Perry Barr custody suite and was informed that Mr. Jukes was not known to the service. She stated that if she had been aware that he was open to the HTT she would have sought information about his involvement and would have made the team aware that he was in custody and the events of the previous evening. It was not established during the inquest and has not been established in BSMHT RCA investigation how this breakdown in communication occurred. Evidence was heard that the introduction of the Merit Vanguard system would not give a BCPFT employee in a custody suite access to some information and would mitigate against such circumstances arising again but it doesn't explain why the nurse was left with the impression that he was not known to services. It is not unusual that clinicians from different mental health trusts will need to discuss patients and as full records are not available through the Merit Vanguard this will continue to arise. If reliable information is not being passed there is a risk to life from ill-informed decision making.
3. Despite not being informed by the BCPFT liaison and diversion nurse that Mr Jukes was in custody the HTT were made aware by his wife that he was in custody on the 28th September 2018. She also gave some information about the circumstances of his arrest, further information about the incident and police involvement had been reported to Street Triage during the night and was noted in the RIO notes. Despite this, no psychiatrist visited or attempted to visit Mr. Jukes in custody which it was stated in evidence was the usual practice of the team. It is not known why this was. Not having a robust and effective system to carry out necessary assessments whilst a patient is detained in police custody puts lives at risk.
4. Following his release from custody on the 28th September 2018 and evidence from a psychologist that he was threating suicide and harm to others, on the 2nd October 2018 the HTT's only recorded attempt to contact Mr. Jukes before the 9th October 2018 was a single call (which probably mistakenly went to his wife's phone) on the 4th October 2018. Despite the fact that his location was unknown and he had not attended a planned medical review on the 4th October 2018 there was no email communication to Mr. Jukes (although he had communicated this way with the team before and provided them with his email address) nor a call to his wife to ask her for assistance. There was evidence at inquest from the RCA Author that there should have been more effort to contact him at least from the 4th onwards if not before. Failure to utilise all means of locating a patient whose whereabouts are unknown, who requires assessment and who is not making contact with the team puts lives at risk.
5. It was planned that Mr. Jukes would be discussed at a team meeting on the 3rd October 2018 after the psychologist raised concerns on the 2nd. There is no credible evidence he was discussed or a plan made to locate and assess him. No explanation was provided in evidence nor was evidence given of a strategy to guard against this occurring in future. Therefore there continues to be a risk that plans to discuss patients in meetings will not be followed through which puts lives at risk.
6. On the 9th October 2018 a HTT clinician talked to Mr. Jukes on the phone at which time he sounded intoxicated, was calm and polite, gave his location and agreed to attend an appointment for a medical review on the 12th October 2018 if a bus pass were provided to his location for him to attend. No arrangements were made in an attempt to assess Mr Jukes before the 12th October 2018. By this time there was reason to suspect Mr. Jukes was at risk of harm to self or others, was under the influence of substances, had not had a full assessment by the team, had recently not been engaging with services and his location had been unknown for over a week. This evidence indicates that those making the decision to ask Mr. Jukes to attend on the 12th underestimated his risk and were not pro-active in making contact. The staff involved maintained in evidence that they acted appropriately, evidence was given that this was not the finding of the Root Cause Analysis investigation review panel. In these circumstances to fail to attempt to assess as soon as reasonably practicable a patient who has come back into contact with the team as soon as reasonably practicable puts lives at risk. No evidence was given of specific action to address the decisions that were made on the 9th October 2018 with the individuals involved or the team generally and therefore the risk continues.
7. Throughout the inquest evidence was given of alleged attempted contact and decision making with respect to Mr. Jukes that was not recorded in his BSMHT RIO notes. Furthermore, his Risk Screen was not updated after information came to HTT's attention that affected his risk assessment. There was some evidence that HTT do not have capacity to fulfil their obligation to

	keep records but evidence from some witnesses suggested that they did not view record keeping as a necessity. If, for whatever reason, RIO notes are not an accurate reflection of contacts, actions and decision-making clinicians maybe mis-led or ill-informed creating a risk to life. Evidence was given that there is an e-learning module on the topic of record keeping and a 'Key message' 3 minute video but it is not compulsory for staff to watch the video or feedback on it and staff are not tested or individually audited. Consequently there continues to be a risk that individuals will not comply with their duty to keep proper records and that this noncompliance will go undetected. 8. Evidence was given at the inquest that the reason HTT may not be maintaining good record keeping was due to insufficient capacity arising from a combination of too few staff arising from under-funding of the service and unnecessary referrals being made to the team. Evidence was given that there is work underway to introduce a systems to prevent inappropriate referrals and that funding has been granted for a further two CPNS for HTTs within BSMHT. However the evidence was that this will not be enough to enable staff to have the time to comply with their obligations to update progress notes and risk assessments. If funding is not sufficient to enable staff to fulfil their professional obligations to their patients, lives are at risk.
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 11 September 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: Family of Mr. Jukes I have also sent it to Coventry and Warwickshire Partnership Trust 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	12/07/2019 Signature  Emma Brown Area Coroner **Birmingham and Solihull**