	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Dawn Baxendale, Chief Executive, Birmingham City Council (BCC)** **(2) Roisin Fallon-Williams, Chief Executive, Birmingham and Solihull Mental Health Foundation NHS Trust (BSMHFT)** **(3) Dave Thompson, Chief Constable, West Midlands Police (WMP)**
1	**CORONER** I am James Bennett Area Coroner for Birmingham and Solihull Districts.
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 06/08/2018 I commenced an investigation into the death of Nigel Byron Abbott. On 25 July 2019 I commenced an inquest. On 26 July 2019 I adjourned the inquest until 9 September 2019.
4	**CIRCUMSTANCES OF THE DEATH** Without any warning, over about 3 weeks in July 2018 the mental health of [redacted] ('KF') declined. He was talking about religion, the devil and that he had been chosen by God. He reported the need to protect himself and his family and kept two knives next to his bed. KF rebuffed his family's attempts to get him medical help. On 26 July 2018, KF's brother persuaded him to see his GP. His GP immediately informed Birmingham and Solihull Mental Health Services ('BSMHFT') that KF was suffering with an acute psychotic episode and needed to be assessed. Later that evening, a psychiatrist and psychiatric nurse assessed KF at his mother's address. They identified a threat of violence, KF describing himself as a 'ticking time bomb'. He would not voluntarily submit to treatment and left. They wanted to detain him under the Mental Health Act but were advised mental health beds in the area were full to capacity. On 27 July 2018, BSMHFT internally discussed KF's case and the lack of a bed. BSMHFT contacted BCC, who were responsible for providing approved mental health professionals ('AMHPs') who then collaborate with BSMHFT to co-ordinate Mental Health Act assessments. However, KF's family had persuaded him to voluntarily submit to treatment. His family telephoned the BSMHFT crisis numbers 60+ times in about 12 hours. The majority of those calls did not connect. The few that were answered did not lead to any action, with KF's family being told there was still no bed available or other resource issues. At about 11pm KF was fixated with 'the blood moon'. When Nigel Abbott ('NA' - a stranger) walked past his house, KF shouted that he was the devil and had to die. In a

	sustained and frenzied assault he killed NA. He assaulted him with punches, stamped on his head, used a spirit level, his own walking stick, and stabbed him 52 times with two knives. Following a post mortem the medical cause of death was determined to be: blunt force trauma to the head. KF was charged with murder. On 14 February 2019 a jury found him not guilty of murder by reason of insanity and he remains subject to detention under the Mental Health Act having being diagnosed with an untreatable form of paranoid schizophrenia.
5	**CORONER'S CONCERNS** During the course of the investigation and adjourned inquest, 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. It appears on the current evidence that there is a misunderstanding between the agencies as to how section 135 Mental Health Act 1983 can work in an urgent situation. This includes both whether or not WMP need 24 hours' notice and whether or not a bed first needs to be available. All agencies need to urgently review *the 'Joint Memorandum of Understanding For Mental Health Professionals Requesting Police Assistance With Mental health Act Assessments and s135(1) & (2) Warrants, June 2018'* and their own practices both individually and jointly to ensure that all staff working in this area understand what is achievable and how. The context for this report is: (1) The evidence from WMP is that they do not require 24 hours' notice to execute a section 135 warrant, whereas the AMHPs (BCC) are of the view there was no point in applying for a section 135 warrant because WMP need 24 hours' notice. (2) BSMHFT have stated that BCC refused to co-operate with their Root Cause Analysis process, reviewing what lessons could be learnt from the incident. (3) I was only made aware that BCC had conducted an Internal Management Review Report - that acknowledged AMHPs were fixed on the operational difficulties of applying for the warrant out of hours and police availability as they required 24 hours' notice – by a witness on day 1 of the inquest. BCC had not volunteered this report existed. (4) The BCC Internal Management Review Report – which is designed to be the 'organisational learning process' - confirms that BCC has not learnt lessons from the incident effectively. In the action plan there is no mention of the incorrect belief amongst AMHPs, that WMP require 24 hours' notice, having been corrected. My on-going concern is that the agencies involved in this area are not working together effectively. The consequence is that acutely unwell people who need to be detained, because of the risk they pose to themselves and others, will remain unnecessarily free in public when in fact the agencies have the mechanism to detain them.

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 25 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: (1) The Chief Coroner for England and Wales. (2) The following Interested Persons: • Nigel Abbott's family. • Kierran Fletcher's family. • [redacted] I have also sent it to the following who may find it useful or of interest: • Matt Hancock MP, Secretary of State for Health. • NHS England. • Birmingham and Solihull Clinical Commissioning Group. I am also under a duty to send the Chief Coroner for England and Wales 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	31/07/2019 Signature  Mr James Bennett Area Coroner for Birmingham and Solihull Districts