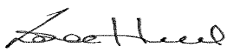
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Birmingham and Solihull Mental Health Foundation Trust (BSMHT)** **2. Chief Constable for West Midlands Police (WMP)** **3. Birmingham City Council**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and 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 21/12/2018 I commenced an investigation into the death of Richard Patrick Carlon. The investigation concluded at the end of an inquest on 22nd July 2019. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had suffered from paranoid schizophrenia for many years and had been under the care of the Home Treatment Team receiving biweekly depot injections. He had a history of relapsing when taking illicit substances namely crack cocaine, cannabis and heroin. He did not engage with the MH team in October 2018. On 13/11/18 he attended Birmingham Heartlands Hospital emergency department with a relapse of his condition due to taking crack cocaine. He remained in the department overnight and following assessment at 10.10 on 14.11.18, when he appeared calm and insightful of what had happened, he was discharged to the care of the home treatment team. At 19.35 on 14/11/18 the deceased called WMP saying he would kill himself. Officers attended his mother's address and detained him under S136 of the Mental Health Act and took him to a place of safety where he was assessed and admitted as a voluntary patient. On the morning of 15/11/18 the deceased asked to go for a cigarette. He did not wait for a doctor's assessment so was escorted by a member of staff. He ran away from the member of staff who caught up with him however he stated he wished to leave but would return at 20.00. Mental Health notified WMP that he was absent but no log was created. At 15.09 the deceased mother rang to report him missing and officers were dispatched to investigate. There was confusion around whether he was in fact missing. At 21.07 he was found safe and well at his father's home where he remained overnight. On 16/11/18 he remained at his father house leaving and returning several times. He last left at 21.30 saying he was going to see a friend. At 22.15 on 16/11/18 the deceased was seen on a lorry webcam to step in front of the lorry travelling along the A45 Coventry Road. He was taken to QE hospital emergency department where he was noted to have multiple injuries including a severe head injury. He was admitted to ITU and subsequently died on 14/12/18. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: POLYTRAUMA ROAD TRAFFIC COLLISION
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. No approved Mental Health practitioner was available to make the Mental Health Act assessment of Mr Carlon on 14/11/18. I was told this was an ongoing problem and was delaying assessments. 2. When Mr Carlon was found safe and well at home WMP did not advise BSMHT. This was a missed opportunity for Mental health to re-engage with Mr Carlon and make a further

	assessment of his condition. Consideration need to be given to how agencies can improve communication.
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 26 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 family I have also sent it to NHS England and the CCG 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	22/07/2019 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**