REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Sandwell Council and Director of Social Services** **2. Chief Executive, Black Country Partnership NHS Foundation Trust**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 30 January 2019, I commenced an investigation into the death of Ms Safoora Alam. The investigation concluded at the end of the inquest on 8 November 2019. The conclusion of the inquest was a short form conclusion of suicide. The cause of death was: 1a Inhalational Burns b Severe Flame Burns
4	**CIRCUMSTANCES OF THE DEATH** i) Ms Alam had complex physical health problems which included a reported diagnosis of Ehlers Syndrome and Fibromyalgia. She had previously suffered a stroke and had on-going complications including pain and mobility issues. ii) She had become increasingly frustrated about her accommodation and her perceived lack of engagement by the agencies involved in her care to find practical solutions to help her with her physical health needs. These included the provision of a ramp. She ultimately decided she would prefer to be in supported accommodation. iii) On several occasions she had threatened to self-harm and had taken impulsive overdoses. A referral was made to the mental health team and the Consultant Psychiatrist's assessment at this time (12 December 2018) indicated that the patient was not suicidal, not depressed, and not psychotic. iv) The Consultant Psychiatrist recorded that the patient was projecting responsibility to services, had traits of personality disorder, was angry and abusive. v) On the 7 January 2019 a further referral was made to the Crisis Home Treatment Team (CHTT) after another overdose attempt. She denied any

	on-going suicidal ideation and was discharged back to her GP. vi) On the 25 January the CHTT were contacted by the Social Worker. The patient had attended Russells Hall Hospital via an ambulance after having been found by her carers with her gas cooker left on and a lit cigarette. Her gas supply was disconnected, and she was given an electrical fan heater. vii) She was visited by the CHTT again and reported fleeting suicidal thoughts due to her physical health problems. She reported no active plans to end her life at the time of the assessment. Her risk of suicide was deemed to be low, however it was noted that this could be escalated due to impulsive behaviours. viii) On the morning of the 28 January 2019 she had a visit from her Social workers for an assessment. However, this wasn't completed due to a reported hostile reception they received. ix) She was further visited by housing officers from the local authority and they noted a worrying decline in her mental state and referred her through to their safeguarding department and her GP for a mental health assessment. x) She was last visited by her carers in the afternoon and seemed to have been in better mood. Later that afternoon, she was discovered in her bedroom and had set fire to her bed and herself. She sustained at least 80% burns to her body and sadly died from her injuries later that day at Queen Elizabeth Hospital.
5	**CORONER'S CONCERNS** 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. Evidence emerged during the inquest that there was inconsistent sharing of documentation and case notes between the agencies involved. 2. There was a lack of a joint Mental Health Trust and social care packages for patients with complex physical health needs or opportunities to convene multi-agency meetings. 3. There was a lack of information gathering prior to the visit to see Ms Alam by the Social workers on the day she died. No contact was made with the Mental Health trust and no assessment took place. 4. The Local authority housing officers did recognise the escalating risk in her mental health state but the mechanism for urgent referral via the safeguarding team and GP was a slow and cumbersome process which didn't work.
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.

	1. All agencies involved may wish to consider reviewing their approaches to sharing of information and approaches to multidisciplinary risk assessments for patients with these complex needs. 2. Social Services may wish to consider reviewing their training for the social workers involved and the importance of obtaining accurate and up to date information prior to any visit. 3. The Mental Health Trust in conjunction with the local authority may wish to consider reviewing their joint agency protocols and developing multi-agency protocols to learn from this tragic incident.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 February 2020. 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. 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	**6 December 2019** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**