	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) The family of Spencer Barr** **2) Probation Service - Young Adults Central Team, Birmingham** **3) Birmingham Women's and Children's NHS Foundation Trust** **4) Change Grow Live, Birmingham** **5) Forward Thinking Birmingham**
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 10 February 2022 I commenced an investigation into the death of Spencer George BARR. The investigation concluded at the end of the inquest . The conclusion of the inquest was; Drug related
4	**CIRCUMSTANCES OF THE DEATH** On 09/12/2021, Spencer was found unresponsive at his home and was declared deceased by paramedics at 14:44. Post-mortem and toxicological analysis confirmed that he had died due to an overdose of drugs. He had a very long history of substance misuse and labile mental health, with periods of stability and prolonged and recurrent episodes of instability due to his drug misuse. He suffered a deterioration in his condition and further overdoses in November 2021 and at the time of his death, he was under the care of the probation services, addiction services and mental health services. Following a post mortem/Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Opioid [redacted]) poisoning. Cocaine toxicity. Pregabalin toxicity.** **1b** **1c** **II Steato-hepatitis**
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. In the months prior to his death, Spencer had been under the care of multiple agencies,

	including Referral Management Team (RMC) (part of Birmingham Women's and Children's NHS Foundation Trust), as well as the addiction service Change Grow Live (CGL); the Young Adults Central Team of the Probation Service; and Forward Thinking Birmingham. 2. I heard evidence that full circumstances surrounding Spencer's deterioration and drug relapse in November 2021 - namely that he had received a significant back payment of benefits totalling over £5,000 from the DWP resulting in him purchasing drugs and overdosing - were not adequately conveyed between agencies, and as such agencies were unaware of the heightened risk of potential self harm and death that was posed by these circumstances. Inter-agency co-operation therefore appears to be inadequate, and consideration should be given to ensuring clinicians receive better training when it comes to the sharing of relevant information between agencies. 3. I heard evidence that Birmingham Women's and Children's NHS Foundation Trust are now taking steps to improve intra-agency co-operation in an attempt to mitigate against the risk of further deaths in the future. However, I heard evidence that other agencies may not be aware of their own limitations when it comes to inter-agency co-operation. For instance, CGL gave evidence that they had no concerns regarding their co-operation with other services, but Birmingham Women's and Children's NHS Foundation Trust indicated that the connections between their respective agencies was poor. I am therefore concerned that there is no universal approach being taken by all agencies to improve inter-agency cooperation, and consideration should be given to the formation of a working group being set up between all agencies to ensure a coordinated approach is taken. 4. Additionally, I am concerned that there appear to be no central points of contact for agencies to facilitate that co-operation. I heard evidence that CGL has no central point of contact for referrals being made/to allow sharing of information - instead relying on information being conveyed via specific individuals. I am therefore concerned that where there is no central point of contact, there is a risk of information not being passed on in a timely manner when a specified person is absent from work for whatever reason. Consideration should be given to central points of contact being created within each agency, and ensuring that those points of contact are shared between agencies to ensure information can flow freely between them. 5. Furthermore, I heard evidence that certain organisations do not accept direct referrals or share information between agencies. For instance, I heard that CGL solely depend on referrals from GP practices and do not allow referrals direct from other agencies. Consideration therefore should be given as to whether there a better system of interagency referral is possible and feasible.
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 14/07/2022. 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** 1) The family of Spencer Barr 2) Probation Service - Young Adults Central Team, Birmingham 3) Birmingham Women's and Children's NHS Foundation Trust 4) Change Grow Live, Birmingham

	5) Forward Thinking Birmingham I have also sent it to the CQC 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	**19 May 2022**  Signature: **Adam Hodson** **Assistant Coroner for Birmingham and Solihull**