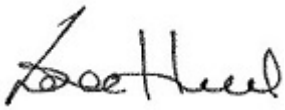
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. HEREFORD & WORCESTER HEALTH AND CARE NHS TRUST** **2. HEREFORD AND WORCESTERSHIRE ICB**
1	**CORONER** I am Louise Hunt Senior Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under 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 25 July 2022 I commenced an investigation into the death of Carl Robert ELLSON. The investigation concluded at the end of the inquest. The conclusion of the inquest was - Suicide
4	**CIRCUMSTANCES OF THE DEATH** The deceased was found in a wooded area [redacted] with a fatal self-inflicted wound [redacted] on 16/07/22 and was confirmed deceased at 19.15. He had sent a text message to his wife at 12.37 indicating he was taking things into his own hands and she had alerted the police. Had had been suffering from anxiety and insomnia following the breakdown of his relationship. He was being cared for by his GP. During an assessment on 13/07/22 his GP was concerned about suicidal ideation and referred him urgently to the home treatment team. They carried out a telephone assessment the same day due to the deceased being COVID19 positive, and the home treatment team confirmed he presented as calm and rational and denied any imminent risk to himself. Further medication was advised and prescribed. He was contacted by his GP on 14/07 when he reported feeling a lot better. He was also seen briefly by his GP in the corridor of the practice on 15/07/22 when he attended for a vitamin B12 injection and was noted to be brighter. He left a note indicating his intentions. Following a post mortem, the medical cause of death was determined to be: **1a Haemorrhage** **1b Incised wound** [redacted] **1c** **II**
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. On 13/07/22 Dr Ellson's GP needed to arrange an urgent mental health review as Dr Ellson had presented with suicidal ideation. The GP had significant difficulties trying to contact the Mental health team with messages giving incorrect numbers. My concern is that the system

	for GPs to contact mental health teams for urgent reviews is not clear nor safe. 2. Once contact had been made and a request was made for Dr Ellson to be assessed by the mental health team, the system in place is for the patient to call the mental health practitioner. My concern is that the patient is likely to be in crisis, which is why a referral is being made, and the burden should not be put on them to make the call. 3. The GP caring for Dr Ellson on 13/07/22 was unaware that she could make a request for a psychiatric review of the patient. The inquest heard how this was not well known by local GPs. My concern is that GPs should be fully aware how to request an urgent psychiatric review for patients.
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 February 2023. 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:- Dr Ellson's family Omberdsley GP practice. I have also sent it to the Medical Examiner, NHS England, 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	**20 December 2022** Signature:  **Louise Hunt** **Senior Coroner for Birmingham and Solihull**