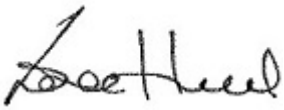
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Constable for West Midlands Police** **2. Birmingham and Solihull Mental health NHS Foundation Trust** **3. Birmingham and Solihull Integrated care board** **4. University Hospital Birmingham NHS Foundation Trust** **5. Secretary of state for Health**
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 18 January 2022 I commenced an investigation into the death of Leroy Patrick HAMILTON. The investigation concluded at the end of the Inquest. The conclusion of the Inquest was: Drowned whilst suffering an acute psychotic relapse

4	**CIRCUMSTANCES OF THE DEATH** Mr Hamilton was known to suffer from reactive depression and psychosis and had been under the care of the mental health team since 2017 when he was detained under the Mental Health Act having deliberately self-harmed by stabbing. Since that time, he had been under the care of the community mental health team with a period of care under the home treatment team in July 2021 following a short admission for a relapse in his condition. At his last review in September 2021, he was noted to be well but concern was expressed about lack of compliance with medication due to some side effects. On 02/12/21 he was noted by a resident at his shared accommodation to be hallucinating, having smashed a window and threated to eat the glass. Police and paramedics attended and he was taken to Good Hope Hospital emergency department where he arrived at 01.45. He was assessed by the mental health liaison service and a psychiatric doctor as needing a full Mental Health Act assessment which was undertaken at 11.30 on 03/12/21. The assessment concluded that he did require further treatment due to a relapse in his condition caused by non-compliance with his medication. He agreed to a voluntary admission, further assessment and recommencement of his medication. He remained in the Emergency department whilst attempts were made to find a bed. At the time there was a national shortage of mental health beds. Staff from the hospital notified the police that he had left the department at 13.41 and that he was at risk of harming himself. There was a failure to treat Mr Hamilton as a missing person at this time, a failure by the mental health services to refer him to the home treatment team for a safe and well check and he was not assessed by the street triage team. At 18.58 police were notified by his landlord that he had left his property following a mental health episode and he was reported to have drunk bleach. No action was taken in relation to this log. At 19.51 police found Mr Hamilton walking on the footpath alongside the dual carriageway near The Fort shopping village after a member of the public reported seeing a man walking in the road. Mr Hamilton reported to officers that he suffered from depression and was out walking to clear his head. Police noted that he was cold and wet and had recently been assessed at Good Hope Hospital and he agreed to be taken to Birmingham Heartlands hospital for further assessment. At the hospital he was triaged by a nurse and noted to be suicidal. He was taken to the escalation room to wait to be assessed. He was not seen again and was noted to be missing from the department at 05.28 on 05/12/21. It is not known when he left the department. There was a failure to report him missing at this time. On 06/12/21 the deceased was found by a member of the public who was walking his dog, in the middle of the river [redacted] Stechford lying on his back on a rock. He was confirmed deceased at the scene by [redacted] at 12.20. His whereabouts since he left the emergency department on or around 4/5th December 2021 are unknown and whilst he had previously indicated suicidal ideation, his intentions at the time of his death are unknown. There were several failures in his care which amount to missed opportunities to help Mr Hamilton; however, it is not possible to say whether the outcome could have been different. Following a post mortem, the medical cause of death was determined to be: **1a Drowning** **1b Psychosis** **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. **Lack of inpatient mental health beds and lack of Psychiatric decisions unit (PDU) spaces**: The inquest heard how there was a regional and national lack of inpatient beds and spaces in PDU. Consideration is needed urgently to fund further mental health beds and PDU spaces to ensure patients are not kept unattended in extremely busy emergency departments. 2. **Safe space**: The inquest heard how it is often the case that due to the lack of inpatient beds and PDU spaces patients are often left in the Emergency department unattended or sent home with periodic reviews by the home treatment team whilst waiting for a bed. This means that acutely ill mental health patients are often left for long periods without any specialist care, support or observation. Consideration should be given to setting up a safe space where patients can wait for a bed or PDU space which is able to cater for their special needs and keep them safe. 3. **Multi agency protocol for informal missing patients**: The inquest heard how there is no agreed protocol to deal with informal patients who abscond from emergency departments. Consideration should be given to setting up an agreed protocol so that all agencies involved understand their respective roles and responsibilities. 4. **WMP Missing person investigations**: The inquest heard how on 2 occasions (03/12/21 and 07/12/21) there was a failure to treat Mr Hamilton as a missing person when he was reported as missing. On both occasions he should have been treated as a high risk missing person. This raises a serious concern that staff do not understand when people should be classified as missing. Consideration should be given to ensuring staff properly understand how to assess if someone should be treated as a missing person and WMP should consider whether further training is required. 5. **WMP risk assessments for missing persons**: When Mr Hamilton was first reported as missing no risk assessment was undertaken about his level of risk to himself. The call had confirmed he was at risk of harming himself. The leads to a concern that staff do not understand when and how to risk assess incidents and when to identify high risk incidents.
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 9 March 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 : The family of Mr Hamilton 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	**11 January 2023** Signature:  **Louise Hunt** **Senior Coroner for Birmingham and Solihull**