	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** (1) The Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care, Department for Health. (2) NHS England. (3) NHS Digital. (4) NHS Birmingham and Solihull Integrated Care Board. (5) Chief Executive, Birmingham and Solihull Mental Health NHS Trust. (6) Chief Executive, Birmingham City Council.
1	**CORONER** I am James Bennett Area 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 3 January 2023 I commenced an investigation into the death of **PETER MARTIN AARON FLEMING.** The investigation concluded at the end of the inquest on 4 July 2023.
4	**CIRCUMSTANCES OF THE DEATH** Peter had a long history of depression, anxiety, and reported suicide attempts. He had acknowledged his reluctance to always engage fully with the treatment offered. On 3/08/22 he was referred to the home treatment team for crisis intervention. After poor engagement he was transferred back to the community mental health team. On 14/10 he was detained by police under section 136 mental health act after expressing suicidal ideation. He told a psychiatric liaison service nurse he had no ongoing suicidal ideation and was referred to the community mental health team and his GP. He contacted the crisis team on 30/10. He was telephoned by a mental health nurse on 31/10, and Peter reported upset about personal issues but no suicidal ideation. On 31/10 he also contacted RELATE and had a telephone consultation with his GP, reporting worsening mental health in part because of a delay in his medication being prescribed, but reported no suicidal ideation. On 8/11 he called the crisis team reporting upset but no suicidal ideation. This prompted a community mental health team nurse on the 9/11 to try without success contacting Peter on the telephone. On 10/11/22 Peter was found deceased in his flat having taken a deliberate overdose of his prescribed medication. At the time of his death he was on the waiting list to be allocated a mental health care co-ordinator and there had been no multi-disciplinary meeting with all teams involved to agree how best to work with Peter. His cause of death was confirmed at post-mortem: 1a Carbamazepine toxicity. The conclusion reached was death was a consequence of suicide.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. The **MATTERS OF CONCERN** are as follows:

1. There continues to be a chronic lack of resources to treat seriously mentally ill patients in Birmingham and Solihull. In the summer of 2022 Birmingham and Solihull Mental Health Trust ('BSMHFT') wanted to admit the deceased to an inpatient psychiatric unit, however, no bed was available, and he remained in the community. Shortly before his death, the deceased had been detained by the police under section 136 of the mental health act. There was no available 'place of safety' and he had to be taken to an emergency department. The police, BSMHFT, and hospital Drs agreed the deceased needed to be assessed under the mental health act, however Birmingham City Council could not provide an approved mental health practitioner ('AMPH') to attend in a 24-hour period. When the section 136 lapsed the deceased was discharged home after a review by a mental health nurse. At the time of his death the deceased was on BSMHFT's waiting list for a care-coordinator. The lack of care-coordinators, mental health inpatient beds, 'place of safety', and AMHPs, presents a risk seriously mentally ill people are not receiving necessary treatment. The evidence is that these issues are a consequence of a chronic lack of resources at a local and national level. The Birmingham and Solihull coroners have been repeating identical concerns in Prevention of Future Death Reports for many years.
2. BSMHFT utilizes self-contained specialist teams. The deceased was treated by (a) crisis team/home treatment team, (b) community mental health team, and (b) psychiatric liaison team. The evidence demonstrated communication between the specialist teams was not effective and this caused delays. For example, the psychiatric liaison team nurse that reviewed the deceased updated the community mental health team. However, the GP could not prescribe the deceased's medication in October 2022 because it had not been approved by the community mental health team consultant via an ESCA and the deceased went without his medication. The deceased's GP had to contact the community mental health team directly notwithstanding the psychiatric liaison nurse's involvement. The deceased cited this delay as making his mental health worse shortly before his death. My concern is communication between the specialist teams is not effective enough. BSMHFT's RCA action plan is to seek assurance from the CCG/ICB that communication between the specialist teams is being strengthened. My concern is that this does not go far enough and there should be consideration of a formal process or policy.
3. Carbamazepine management was proposed in 2012 to manage the deceased's mental health however this was not picked up by his GP and was only noted by a BSMHFT consultant in August 2022. Therefore, the deceased went 10 years without this medication. BSMHFT could not explain at the inquest why this omission had not been identified sooner. BSMHFT's RCA action plan does not have any action to avoid a repeat occurrence. My concern is this issue indicates a problem with process and systems and further consideration is required to avoid a repeat occurrence.
4. The deceased's GP raised concerns that different health organisations use different digital systems that do not communicate with each other. Further, GPs often do not get important patient updates from primary care organisations for many days or weeks. (See examples above: the GP did not pick up the carbamazepine prescription, and could not prescribe the medication in October 2022). My concern is communication between different health organisations is not as effective as it could be and important information is being missed, and consequently a material delay in treatment is occurring.
5. The deceased's GP raised concerns that current resources do not allow GPs to pro-actively check patients are collecting prescribed medication due to excessive patient lists. My concern is that this is a consequence of lack of resources at a national level.

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.

ACTION SHOULD BE TAKEN

6 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 8 September 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: (1) Peter's family. I have also sent a copy to the following who may find it of interest: (1) Peter's GP, [redacted], Senior Partner, Druid Group. (2) Chief Constable. West Midlands Police. 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	**14 July 2023**  **James Bennett** **Area Coroner for Birmingham and Solihull**