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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>**Birmingham & Solihull Mental Health NHS Foundation Trust.** |
| 1 | **CORONER**<br><br>I am Susanna Rickard, Assistant Coroner for Birmingham and Solihull. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 16 May 2023 I commenced an investigation into the death of Paula LENIHAN. The investigation concluded at the end of the inquest. The conclusion of the inquest was:<br><br>Natural causes, contributed to by misuse of prescribed and controlled drugs. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>**On 06/03/2023 Paula Lenihan was found deceased at her home address. She had a complex medical history with both physical and mental health problems. Post mortem results revealed she had died as the result of heart disease and that she had a combination of drugs in her system suggestive of excessive use, or overdose. Together these may have caused toxicity but none were at levels which individually would have caused fatality. It is not possible to ascertain her state of mind shortly prior to her death, but when seen by her GP on 01/03/2023 no particular concerns had been noted.**<br><br>Following a post mortem the medical cause of death was determined to be:<br><br>**1a Ischaemic and hypertensive heart disease**<br><br>**1b**<br><br>**1c**<br><br>**II Combined toxicity** [redacted] |

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| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. -<br><br>1. The evidence given on behalf of the Birmingham & Solihull Mental Health NHS Foundation Trust was that in addition to this present case, where the deceased's risk assessment was not updated between November 2021 and her death in March 2023 despite circumstances which I was told ought to have triggered an update, there were a further number of cases within the Trust in which Root Cause Analysis reports had been produced, where it had also been found that risk assessments were not being completed in line with expectations; further, that it was not clear why this was happening.<br><br>2. If risk assessments are not being properly completed or updated, then there is an obvious risk of deaths occurring in the future, as a result of insufficient recording of risk. The fact that risk-relevant information may be recorded in the body of clinical notes is not reassuring, because a risk assessment or risk summary ought to capture the most salient risk information so that a professional looking quickly can absorb it; this is all the more important where professionals are under time pressure.<br><br>3. The evidence given to me was that a 'task and finish group' has been set up to address the issue, which expects to have concluded by early next year, i.e. 2024, and that this group will be addressing matters as they are found rather than waiting until the final stage of its existence early next year. The evidence was that this group is at an early stage, with meetings considering the terms of reference and also, recently, the most appropriate persons to contribute to the group.<br><br>4. In the circumstances I am concerned that currently there is an extant issue within the Trust about the completion of risk assessments being, on a number of occasions, unsatisfactory. The task and finish group is at an early stage and I do not know what it is going to do, or when. I therefore cannot be reassured that the issues around risk recording which that group is going to examine have, at this point in time, been addressed. It seems to me that they continue to exist, because there has been no evidence to tell me otherwise.<br><br>5. In my opinion action needs to be taken to prevent the occurrence or continuance of the issue within the trust around the insufficient recording or updating of risk assessments, or to eliminate or reduce the risk of death created by such circumstances. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |

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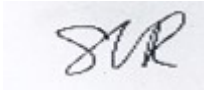
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 27 November 2023. I, the coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed. |
| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>The family of Paula<br><br>I have also sent it to the regional Medical Examiner, ICB, NHS England, CQC, who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **2 October 2023**<br><br>Signature:  <br><br>**Susanna Rickard**<br><br>**Assistant Coroner for Birmingham and Solihull** |