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|   | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>St Andrew's Healthcare<br>The Care Quality Commission<br>Chief Constable of West Midlands Police |
| 1 | **CORONER**<br><br>I am Ms Emma Brown, HM Area 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 6 December 2022 I commenced an investigation into the death of Steven Sanders. The investigation is ongoing and is currently listed for a Jury inquest to commence on the 5th February 2024. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Steven Sanders was a detained patient under section 3 of the Mental Health Act at the Hawksley Medium secure ward of St Andrew's Healthcare ('SAH') in Birmingham. He required treatment for paranoid schizophrenia. On the 20th November 2022 Steven had appeared well and had been allowed authorised leave from the unit during the afternoon returning to the ward at 14:10. For the rest of the afternoon he appeared his normal self and had spent time around the ward and in his room. Records show him as being asleep during the early evening but when staff went to wake him for medication at 22:10 he was unresponsive, a nurse identified he wasn't breathing and an ambulance was called. Despite resuscitation attempts Steven was pronounced deceased at 23:04. Following a post mortem examination a pathologist gave the cause of Steven's death as arising from coronary artery disease. However, there has since come to light reason to suspect Mr Sanders might have taken [redacted] before his death calling into question the natural cause. This suspicion arises from:<br><br>1. Mr Sanders had a history of drug dependence (this was not known to the Coroners or Pathologist at the time of the post mortem);<br>2. [redacted]<br>3. [redacted]<br>4. there is evidence Mr Sanders made comments to other patients [redacted] |
| 5 | <u>**CORONER'S CONCERNS**</u><br><br>During the course of the investigation 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. - |

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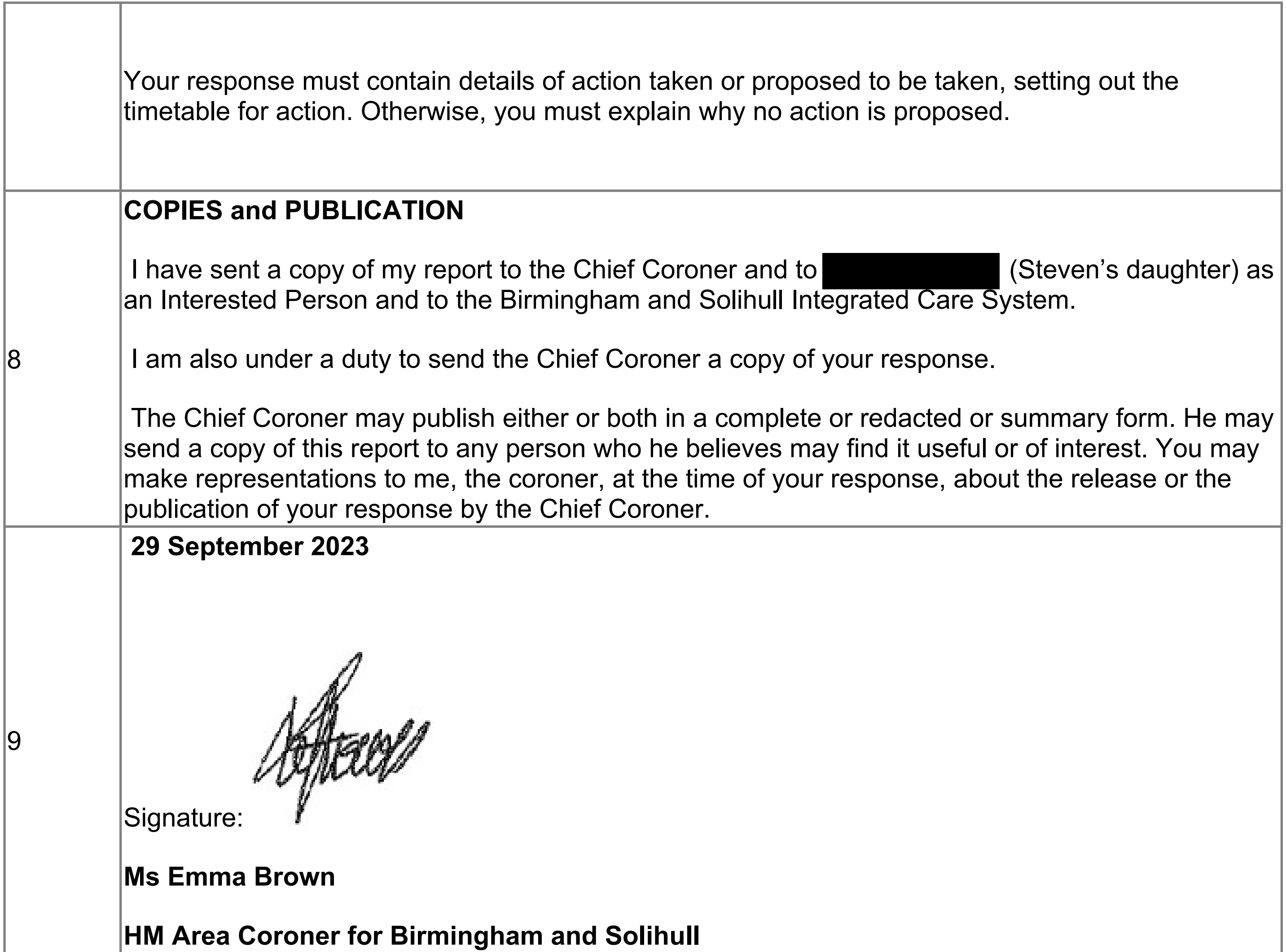
| | Initially there was no evidence that illegal drugs were more widely being used and supplied within SAH and the hospital provided evidence of its policies and procedures for searches to address this risk and asserted that these policies and procedures were in appropriate operation.<br><br>However, on the 24th July 2023 I was informed that during a routine room search of Hurst ward (another secure ward in SAH Birmingham) over the weekend of the 22nd/23rd July 2023 a quantity of drugs and a lighter were discovered in a patient's room. The patient (Patient A) whose room these items were found in alleged that these drugs were given to him by Mr Steven Sanders when they were both patients on Hawksley ward. SAH has confirmed that the patient and Mr Sanders were cared for on Hawksley ward at the same time prior to Mr Sanders' death. The following further information was then provided by SAH on the 27th July 2023: the room search occurred on 23rd July, found in Patient A's room, Patient A disclosed the substance from Mr Sanders on the day he died (20th November 2022) after Mr Sanders returned from unescorted leave, Patient A got from another patient, Patient B, whilst on Hawksley Ward. Patient A also disclosed that Patient B had brought into Hawksley Ward.<br><br>Subsequently, on the 24th July 2023 Patient A was found with what appeared to be cocaine in his room and he had hidden it in his anus during the room search on the 23rd July.<br><br>I wrote to the CQC and WMP on the 28th July 2023 explaining my concerns. I have not yet received any update on the action taken to date by the CQC. It was agreed at a meeting with WMP on the 11th August 2023 that they would conduct some enquiries, but I have not had any update on those enquiries.<br><br>Today I have become aware that on the 24th September 2023 a report was made to West Midlands Police that a patient had been supplying drugs to other patients. The details were that he had been keeping . Three patients had tested positive for and a further 5 patients were acting under influence.<br><br>Also, on the 24th September 2023 another detained patient (Patient C) was found deceased lying on his bed in unexplained and unexpected circumstances. A separate investigation is being undertaken into Patient C's death and it remains to be ascertained whether his death was drug related.<br><br>I am deeply concerned that the risk of illicit substance use is not being adequately mitigated at SAH and there is an endemic problem. This risk creates an obvious risk to life not merely from the risk of death inherent in illicit substance use but also because the population of SAH is particularly vulnerable: many suffer from mental illness affecting their judgement and assessment of risk, there will be a history of drug use amongst many patients and those patients taking illicit substances may not have an accurate perception of their tolerance due to their time in detention. The risk of death is also increased by the current presence of (new and highly potent synthetic opioids) being supplied within the West Midlands.<br><br>There needs to be an urgent and thorough investigation into all these incidents to identify how drugs are entering and being distributed within SAH and how this risk can be mitigated as far as possible in the future. |
| 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. |
| 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 24 November 2023. I, the coroner, may extend the period. |



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| | 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 [REDACTED] (Steven's daughter) as an Interested Person and to the Birmingham and Solihull Integrated Care System.<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 | **29 September 2023**<br><br>Signature:<br><br>**Ms Emma Brown**<br><br>**HM Area Coroner for Birmingham and Solihull** |