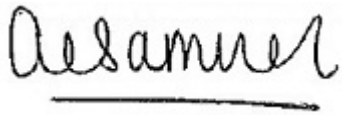
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Sandwell and West Birmingham NHS Trust and Birmingham and Solihull Mental Health NHS Foundation Trust.**
1	**CORONER** I am Ana Samuel, Assistant Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this 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 1 June 2023 I commenced an investigation into the death of Andrew BOWLES. The investigation concluded at the end of the inquest. The conclusion of the inquest was; Drowned in a canal, having recently attended hospital suffering with a deterioration in mental health. It is unknown how he entered the water nor his intent at the time.
4	**CIRCUMSTANCES OF THE DEATH** **On 15th May 2023 the deceased, who had an extensive mental health background including self-harm, was taken to Birmingham City Hospital, concerns having been raised after he had been seen running in and out of traffic. He was deemed medically fit and was referred for psychiatric assessment. Following assessment referrals were made to the home treatment team and the homeless pathway team, there being no undue concerns noted by psychiatric liaison. Discharge was documented at 23.30, with an expectation that the deceased would remain in A&E until the following morning. CCTV footage showed the deceased leaving the hospital grounds at 23.28. The deceased was found face down in the canal under the road bridge of Dudley Road at 6.34 on the 16th May 2023, it being unclear how and when he entered the water.** Following a post mortem the medical cause of death was determined to be: **1a Drowning** **1b** **1c** **II**
5	**<u>CORONER'S CONCERNS</u>** 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. Mr Bowles had an extensive mental health history with incidents of self-harm and suicidal intent. 2. On 15th May 2023 Mr Bowles had told attending paramedics and the triage nurse at Birmingham City hospital that over the last 24 hours he had been hearing voices

	that were telling him to hurt himself and others. When he was seen, post triage, by the doctor (SHO) [redacted] Having been deemed to have no physical health needs a referral was made to the psychiatric liaison team. 3. The mental health liaison nurse from Birmingham and Solihull mental health NHS foundation trust did not have a log in to be able to directly access City Hospital records, but rather relied on a colleague to access any notes and provide a verbal handover. Further, she stated in evidence that her assessment may have taken place prior to the A&E notes being put onto the system, as she was unaware that Mr Bowles had been experiencing command hallucinations and had thoughts of self-harm, the same being denied when she saw him less than an hour later. Her evidence was clear, that had she been privy to this information, it would have put a different angle on the assessment and would have led down the route of psychiatric review for potential admission. 4. I am concerned that the mental health liaison nurse undertook her assessment without having access to City Hospital records, which contained essential information that would have impacted on her assessment. I am concerned that there may still be a risk to the life of some patients if the mental health liaison team and Birmingham City Hospital are not ensuring that essential patient records are being appropriately shared and read prior to diagnosis and treatment. The situation may well be the same at University Hospitals Birmingham, given that Birmingham and Solihull Mental Health NHS foundation Trust also run a mental health liaison service in the A&E department.
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 27 December 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 next of kin. I have also sent it to the Medical Examiner, Birmingham and Solihull Integrated Care board, Public Health England, Department of Health, University Hospitals Birmingham NHS Foundation Trust 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	**31 October 2023** Signature:  **Ana Samuel** **Assistant Coroner for Birmingham and Solihull**