	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Birmingham and Solihull Mental Health NHS Foundation Trust ('BSMHT') and Birmingham and Solihull Intergrated Care System ('ICS')**
1	**CORONER** I am Emma Brown HM 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 5 June 2023 I commenced an investigation into the death of Leya Amra ADRIS. The investigation concluded at the end of the inquest . The conclusion of the inquest was; Drug related
4	**CIRCUMSTANCES OF THE DEATH** **Miss Adris was pronounced deceased by paramedics at her sister's home, [redacted], Birmingham, at 09:07 on the 18th March 2023 after she was witnessed to suffer an episode of fitting. Post mortem testing has identified that her death was due to [redacted] toxicity. Miss Adris had also taken excessive [redacted] Both medications are used for the management of anxiety but were not prescribed to her and therefore she may not have known the appropriate doses. Miss. Adris had recently sought support for increased anxiety and suicidal thoughts but denied any immediate intent. She had spent a lot of time with family in the days before her death and had made detailed plans for the subsequent days. There was nothing to indicate that she was suicidal and is likely to have accidentally overdosed.** Following a post mortem the medical cause of death was determined to be: **1a Acute fatal toxicity** **1b [redacted] overdose** **1c** **II Mental Health issues**
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.* On the 13th March 2023 Miss Adris had a telephone review with [redacted], GP at The Park Medical Centre, who recorded that she had been taking [redacted] for 2 weeks, had spoken to the primary mental health worker and had been referred to 'Our roots' for therapy and had an appointment. She also recorded: *"states nothing seems to be helping her at present, states that she feels like things are worsening daily, states she has very poor concertation-cant watch TV and having to walk out at work as cant concentrate...she*

has a history of severe mental illness-with her being under HTT and sectioned in 2019. Patient states she isnt as bad as she was then but her mood is getting worse. States she wants to go to sleep and not wake up asked if she has suicidal thoughts-states she has but wouldn't act on it right now-asked why states couldn't do it to her family. Advised therefore for referral to psychiatry."

2. [redacted] explained in her evidence that although she knew that Miss. Adris had seen the primary mental health team nurse, [redacted], on the 8th March and had another appointment arranged for the 30th March, she specifically wanted to make the referral to the community mental health team so that the opinion of a psychiatrist could be obtained if necessary. She said she felt this was warranted because of Miss. Adris's history that she was getting worse daily and now couldn't concentrate alongside her significant history. She filled out a BSMHT form entitled 'Referral form for access to secondary mental health services' which contained the record of the review and selected from the urgency options 'Within 1 to 4 weeks of referral for all other referrals that do not fit within the above two categories [for assessment within 24 hours or symptoms of psychosis], but who require assessment and treatment by secondary mental health services.' On the electronic submission she marked the referral as 'urgent' as the only options are 'urgent' or 'routine' and she didn't feel this was routine.

3. That referral was received by the single point of access ('SPOA') but as Miss. Adris was under the care of the primary mental health team/neighbourhood team it was not sent to the community mental health team ('CMHT') but sent back to Mr. Agyepong at the primary mental health team. A statement from [redacted], Clinical Services Nurse Manager, Little Bromwich Centre, provided evidence that this is the system in operation for patients on the case list of the primary/neihbourhood mental health team. [redacted] reviewed the referral on the 14th March and decided there was no need to bring Miss. Adris's appointment forward or refer her to the CMHT as her thoughts were not active and there didn't appear to him to have been a significant change.

4. [redacted] said she and her colleagues at the practice were not aware that the referral would not be viewed by the CMHT (she also suspected this was the case for other GPs) and if she had known this she would have called up the CMHT directly because she specifically wanted a psychiatrist's input. She said that if she'd wanted a further opinion from [redacted] she would have contacted him directly. In essence she wanted a second opinion from the secondary care team. She also explained that if she had been made aware that the referral had been sent back to the primary mental health team and no action was being taken she would have contacted the CMHT directly to raise her concerns but she wasn't informed of the outcome of the referral before Miss. Adris's death. [redacted] was aware that [redacted] had seen the referral and was keeping his appointment on the 30th as he had made a record in the surgery's records but she didn't realise this was the end of the referral which she presumed would still be being dealt with by the CMHT.

5. When a GP has referred a patient for review and assessment by secondary services I am concerned that it is not safe that there is no consideration of that referral by secondary services and the GP's opinion that secondary services need to be involved is unilaterally over-ruled.

6. I am equally concerned that not all GPs are aware that their referral to secondary services will not necessarily be considered by secondary services and that the GP making the referral was not informed that it had, in effect, been rejected.

7. If there are grounds for a GP to believe review and assessment is necessary by secondary services, it creates a risk to life if that review does not take place. Whilst the evidence gives no reason to doubt the expertise and competence of primary care mental health practitioners the fact that they are not caring for patients with conditions requiring management by psychiatrists means that they will not have the same familiarity with such conditions and when psychiatrist input is required. In this case it was my conclusion that on

	the 14th March the primary mental health practitioner did underestimate the significance of the report of daily deterioration and a new difficulty concentrating for a patient with a history of serious mental illness that had required detention for treatment.
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 3 January 2024. 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: [redacted], next of kin. I have also sent it to the CQC and [redacted] 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	**8 November 2023** Signature:  **Emma Brown** **Area Coroner for Birmingham and Solihull**