	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive, Birmingham and Solihull Mental Health Foundation Trust. 2. NHS Birmingham and Solihull Integrated Care Board. 3. The Rt Hon Victoria Atkins MP, Secretary of State for Health and Social Care.
1	**CORONER** I am James Bennett H.M. 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 13 July 2023 I commenced an investigation into the death of Philip Laurence Justin MALONE. The investigation concluded at the end of the inquest on 14 November 2023.
4	**CIRCUMSTANCES OF THE DEATH** Mr Malone was diagnosed with treatment resistant schizophrenia in 1983 and had been sectioned multiple times. In May 2023 he was diagnosed with adult autism. At a review on 31 May he was considered to be stable. On 15th June a routine clozapine review identified sub-therapeutic levels but this was not notified to his clinicians. Sub-therapeutic levels of clozapine are likely to have contributed to a worsening in his symptoms. Around 24th June he was noted to have suffered a significant deterioration - with symptoms of thought disorder, anxiety, and responding to hallucinations - and following a mental health act assessment on 28th June clinicians wanted to detain him under section 2. No inpatient psychiatric bed was available. Whilst he awaited a bed, he remained in the community with daily visits from the mental health team. Last contact was on 1st July when he accepted his medication and appeared more settled. There was no answer when he was visited on 2nd July. His room at supported accommodation was entered on 3rd July and he was found deceased [redacted]. Recently he had expressed no suicidal ideation. Post-mortem examination confirmed the medical cause of death was: 1a Cervical spinal cord injury. 1b Laceration [redacted] 1c II The conclusion of the inquest was that death was the consequence of suicide.
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. Despite recognising Mr Malone needed to be admitted to a psychiatric hospital in June 2023 but there was no bed capacity, BSMHFT' RCA report identified no remedial action.

	2. The Patient Safety Manager [redacted] gave evidence that the lack of psychiatric bed capacity remains an ongoing problem and has not been resolved, and there is a genuine risk of the same problem with another patient in the future. 3. [redacted] added there was an exceptional process, which required a considered decision at a high level, to make a bed available through identifying someone currently occupying a bed space to be discharged. In my view, this process is unsatisfactory as it creates a different set of risks around the patient being discharged, and amplifies the chronic shortage of beds. 4. There was reference to two preceding Regulation 28 Reports to Prevent Future Deaths (both available publicly on the judiciary website) that focussed on the chronic lack of mental health resources in Birmingham and Solihull. In relation to the specific issue of a lack of psychiatric bed capacity, in the case of Peter Fleming (no bed was available in August 2022) BSMHFT's response (September 2023) referred to their response in the earlier case of Leroy Hamilton (no bed was available in December 2021). This response (April 2023) stated more resources had been obtained and a collaborative plan had been implemented with NHS Birmingham and Solihull Integrated Care Board. The issue of adequately funding psychiatric beds is a local and national issue. Locally, BSMHFT require their commissioners to provide the necessary funding. My principal concern is that the above dates indicate available psychiatric bed capacity in Birmingham and Solihull remains inadequate. Whilst some action may have been taken it is insufficient to resolve the problem. It follows there is a genuine risk of future deaths directly connected to a shortage of psychiatric bed spaces in Birmingham and Solihull unless further action is taken.
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 19 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: 1. Mr Malone's family. 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	 James Bennett H.M. Area Coroner for Birmingham and Solihull 23rd November 2023