	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. THE CHIEF EXECUTIVE OF DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST** **2. THE CHIEF EXECUTIVE BLACK COUNTRY HEALTHCARE NHS FOUNDATION TRUST**
1	**CORONER** I am Mr Adam Hodson, 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 2 October 2023 I commenced an investigation into the death of Thomas Peter LOXTON. The investigation concluded at the end of the inquest . The conclusion of the inquest was: Suicide
4	**CIRCUMSTANCES OF THE DEATH** **At 16:30 on 21/09/2023 paramedics attended Thomas' home after he was discovered by family members lying unresponsive on his sofa, with empty packets of medication and a hand-written note nearby, and Thomas was subsequently declared deceased. Post-mortem examination confirmed that death was due to an overdose of multiple prescription medications. Thomas had a long history of mental health illness and was under the care of two separate secondary mental health service providers at the time of his death. Investigations post-death revealed incidental areas of learning but none of which were directly causative of his death, and none of which would have prevented his death.** Following a post mortem the medical cause of death was determined to be: **1a** [redacted] **OVERDOSE** **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. **Dudley Integrated Health and Care NHS Tru**st 1. In the inquest, there was evidence that Thomas' family received letters from clinicians from Dudley Integrated Health and Care NHS Trust (DIH) requesting that Thomas made contact with them, which were sent after his death, causing obvious distress to his family. It is not difficult to see that this type of administrative error

	could lead to significant distress to families who are already vulnerable by virtue of their bereavement, and which could give rise to a risk of death. An RCA carried out by DIH identified that action was to be taken - namely that DIH should work with colleagues at Black Country Healthcare NHS Foundation Trust (BCH) to establish and embed the process for notifying of patient deaths. However, this does not appear to be an action that has been identified in BCH's RCA report, and I am concerned by the apparent lack of collaborative working to ensure this process is carried out. 2. Secondly, the evidence on behalf of DIH was that the above action to be taken remains outstanding and has a target completion date that arises after the conclusion of this inquest. I am concerned that if this target is pushed back and/or is not not met, for whatever reason, there is a risk that future deaths will occur. Upon conclusion of the inquest, I am *Functus Officio*, with no power to request updates from the Trust to check and ensure that the targets have been met and changes have been made. Whilst I am grateful for the efforts of reassurance provided by representatives of the Trust at the inquest, I am reluctant to dismiss my concerns, particularly where actions remain outstanding, and I have opportunity to take action now to ensure that the risk of future deaths is reduced. **Black Country Healthcare NHS Foundation Trust** 1. The evidence on behalf of Black Country Healthcare NHS Foundation Trust (BCH) was that there are numerous recommendations as detailed in its Root Cause Analysis (RCA) report that remain outstanding that have target completion dates that arise after the conclusion of this inquest. These dates have been pushed back once already. I am concerned that if these targets are pushed back further and/or are not met, for whatever reason, there is a risk that future deaths will occur. Upon conclusion of the inquest, I am *Functus Officio*, with no power to request updates from the Trust to check and ensure that the targets have been met and changes have been made. Whilst I am grateful for the efforts of reassurance provided by representatives of the Trust at the inquest, I am reluctant to dismiss my concerns, particularly where actions remain outstanding, and I have opportunity to take action now to ensure that the risk of future deaths is reduced. 2. Secondly, in this inquest, there was evidence that Thomas' family received letters from clinicians from Dudley Integrated Health and Care NHS Trust (DIH) requesting that Thomas made contact, which were sent after his death, causing obvious distress to his family. It is not difficult to see that this type of administrative error could lead to significant distress to families who are already vulnerable by virtue of their bereavement, and which could give rise to a risk of death. An RCA carried out by DIH identified that action was to be taken - namely that DIH should work with colleagues at BCH to establish and embed the process for notifying of patient deaths. However, this does not appear to be an action that has been identified in BCH's RCA report, and I am concerned by the apparent lack of collaborative working to ensure this process is carried out.
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 12th April 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) [redacted] - Thomas' mother I have also sent it to NHS England 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	**15 February 2024**  Signature: **Adam Hodson** **Assistant Coroner for Birmingham and Solihull**