	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Birmingham and Solihull Mental Health NHS Foudation 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 23 April 2024 I commenced an investigation into the death of Juliette Kirsty SEWELL. The investigation concluded at the end of the inquest. The conclusion of the inquest was; Suicide
4	**CIRCUMSTANCES OF THE DEATH** **In the afternoon of 16/02/2024, Juliette was discovered unresponsive in [redacted] by a family friend, surrounded by multiple empty packets of medications, and was subsequently confirmed deceased at 13:43. Post-mortem investigations indicated she had died from a fatal overdose. Juliette had been missing since the evening of 14/02/2024 when she left home following difficulties in her personal life and was last seen alive by a friend at around 22:00 on 14/02/2024. Juliette was seen crying on the porch of her friend's home on Fallowfield Road before heading in the direction of [redacted]. She had a history of mental health illness since 2010 and had been under the care of both her GP and her local mental health team. At the time of her death, Juliette had been awaiting a follow-up appointment with the mental health team since January 2023 which had been delayed due to staffing shortages, but it is unlikely that her death could have been prevented.** Following a post mortem, the medical cause of death was determined to be: **1a [redacted] and [redacted] toxicity** **1b** **1c** **II Presence of [redacted], [redacted], [redacted], [redacted], [redacted] and [redacted]**
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. Following Juliette's death, a Structured Judgement Review ("SJR") was carried out which identified steps that have been taken. However, the SJR confirmed that a review of Rio records was being undertaken of those who have not been seen in over 12 months with actions to be identified, and that clinical stratification of current caseload is ongoing. I

	understand that a review or audit of this process is being scheduled to take place at some point in October 2024 (date unknown). 2. Upon conclusion of the inquest, I am *Functus Officio* meaning that my powers cease and I will have no way of checking if the recommended actions have been completed. In the circumstances, where action to be taken is outstanding and when a specific review date has not been scheduled, I am concerned that there is a risk of future deaths occurring. 3. The deadline for a response under this Report should coincide with the Trust's planned review/audit in October, therefore I am hopeful that the Trust will be able to respond swiftly thereafter, and hopefully will be able to confirm that positive action that has been taken and whether any further work is necessary.
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 14/10/2024. I, the Coroner, may extend the period upon request. 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], Sister I have also sent it to the Medical Examiner, ICS, NHS England, CQC, 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	**19 August 2024**  Signature: **Adam Hodson** **Assistant Coroner for Birmingham and Solihull**