	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: All Care In One Ltd via Managing Director,** [redacted]
1	**CORONER** I am James Bennett, H.M. Area Coroner for Birmingham and Solihull areas.
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 4 June 2024 I commenced an investigation into the death **JAVED IQBAL.** The investigation concluded at the end of the inquest on 19/02/25.
4	**CIRCUMSTANCES OF THE DEATH** Javed was aged 57 and had a long-term diagnosis of somatisation disorder and paranoid schizophrenia. He was under the care of mental health services. He was known to drink alcohol to excess and use cannabis regularly, and it was recognised his mood and behaviour could be changeable and erratic. He was last reviewed by mental health clinicians on 29/02/24 when his mental health appeared settled, and he agreed to continue his medication with the next routine review in August 2024. His residential support worker and social worker recognised his behaviour could be challenging but did not consider mental health intervention was required. On 22/05, he had a 9-minute telephone consultation with a GP about a recent chest infection and known COPD with no apparent acute mental health issues. The following day, 23/05, his care co-ordinator telephoned the GP receptionist reporting his carer had reported a 3-4 day history of worsening mood and irrational behaviour, she was advised to set it out in an email for the GP. No email was sent. Carers continued to visit Javed on 23 and 24/05. On 25/05 Javed deliberately ignited his room with flammable liquid and remained in and around the fire for a prolonged period before exiting through a window when the conditions became unbearable. He was combative and aggressive with emergency services consistent with him experiencing a mental health episode. He was sedated and admitted to Queen Elizabeth Hospital Birmingham critically unwell. Despite treatment for major burn injuries and smoke inhalation he went into multi-organ failure and died on 01/06/24. Toxicology indicated he had not been taking his anti-psychotic medication. The conclusion of the inquest was: *Death was the consequence of trauma caused in a deliberately set fire however the available evidence does not reveal his intention in setting the fire.*
5	**CORONER'S CONCERNS** 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 evidence demonstrated there is a continuing risk that All Care In One Ltd staff will not recognise and take appropriate action when a service user presents with serious acute mental health issues. For example: (1) At a fundamental level staff did not understand what is in the best interests of a service user: (a) Carers did not want to embarrass Javed, therefore they felt justified in making repetitive inaccurate contemporaneous records recording behaviour and mood was well despite having serious concerns about his worsening mental health and triggering an urgent call to his GP; (b)

	Then, having contacted the GP two days before his death, the care co-ordinator did not action the request from the GP to send an email setting out these serious concerns in writing. (2) There was no formal internal post-death investigation report. (3) Whilst some post-death internal training has been identified it remains outstanding despite 8 months passing since the death. However, I was not satisfied this training has recognised the above concerns.
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 28 April 2025. 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 of England and Wales and to the following Interested Persons: (1) Family of Javed, (2) Birmingham and Solihull Mental Health NHS Trust, (3) West Midlands Fire Service, (4) [redacted], GP, and (5) Modality GP Partnership. I have also sent it to the Care Quality Commission who may find it useful or of interest. I am also under a duty to send the Chief Coroner of England 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	**3 March 2025**  **James Bennett, H.M. Area Coroner for Birmingham and Solihull**