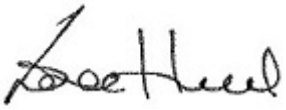
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Birmingham and Solihull Mental Health NHS Foundation Trust • Provident Housing • Birmingham City Council
1	**CORONER** I am Louise Hunt Senior Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this 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 20 July 2023 I commenced an investigation into the death of Matthew John LYNCH. The investigation concluded at the end of the inquest. The conclusion of the inquest was; Killed unlawfully
4	**CIRCUMSTANCES OF THE DEATH** Mr Lynch resided in room 1 in supported living accommodation which was shared with 3 others, including the offender, at [redacted] Birmingham. Between 05.30 and 05.51 on 11/07/23 Mr Lynch was attacked in the garden area outside the property and decapitated by the offender. The offender was known to suffer from treatment resistant paranoid schizophrenia which would be made worse if he stopped taking his medication and took illicit substances. He had been under the care of mental health services for some time. He had last been seen in clinic on 12/05/23 when he admitted he had stopped taking his medication but agreed to restart it and confirmed he had changed his address. Further efforts were made to contact him however he did not respond. There was concern at this time that his mental health condition was relapsing, and his case was discussed in an MDT on 17/05/23. An unannounced visit was made to an address on 24/05/23 when he was not present; however, it is not clear if the CPN attended his new address or the old address which remained on his clinical records. He was spoken to briefly by a CPN on 14/06/23 when he appeared intoxicated but agreed to attend a clinic appointment on 21/06/23 which he did not attend. Further attempts were made to contact him without success, but no attempts were made to contact his family or the landlord. In the days leading up to the attack the offender had been found to use weed at the address and was given a verbal warning on 26/06/23. He smashed up his room on 10/07/23 and was evicted from the property. In the past smashing up his room had been an indicator of declining mental health however this was not known to the landlord and the landlord was unaware he was under the care of the Community Mental Health Team (CMHT). He was taken to City Hospital by the landlord on 10/07/23 as he was concerned about his unusual behaviour but the offender left before being seen. CCTV confirmed he returned to the property at 02.48 on 11/07/23 and was seen in the garden area having an altercation with Mr Lynch around 05.30 before at 05.51 he is seen on CCTV striking Mr Lynch with force. After he was dead the offender decapitated Mr Lynch. At 14.23 the Landlord attended the property after another resident was unable to enter. The offender admitted to the landlord that he had killed Mr Lynch and the police were called. The offender was sentenced to a hospital order for the offence of manslaughter by diminished responsibility.

	Following a post mortem the medical cause of death was determined to be: **1a Multiple sharp force injuries** **1b** **1c** **1d** **II**
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 **MATTERS OF CONCERN** are as follows. **To Birmingham and Solihull Mental health Trust** **1. Internal investigation**: The internal investigation did not address how and whether the offender's use of medication should have been monitored after the clinic visit on 12/05/23. This was important as non compliance with medication was a risk factor for relapse. In addition, during the inquest the trust confirmed they had not spoken to the CPN who attempted to visit the offender on 24/05/23 to verify whether they had attended the old or new address. This was a critical issue as the new address had not been updated on the clinical notes. This raises a concern about the quality of the investigation and whether the Trust is adequately learning from incidents. **To Birmingham and Solihull Mental Health Trust and Birmingham City Council** **2. Mental Health assessments**: The inquest heard evidence that there were barriers to the use of S2 and S3 of the Mental health Act due to AMPH resistance, administrative challenges and resourcing. This raises a concern that incorrect MHA assessments are taking place and patients may be detained on an inappropriate section impacting patient care. A copy of a report prepared by [redacted] is attached. **To Birmingham and Solihull Mental Health trust, Birmingham City Council and Provident housing** **3. Information sharing between agencies and support worker training**: The inquest heard evidence that Landlords have to rely on the information given to them by the residents and do not have access to other key information held by other agencies. This means the landlord is often not aware of key information about an individual. Given the potential for harm for residents and support workers consideration needs to be given to how best to share information to ensure residents are receiving the right care and landlords have sufficient information to be able to monitor residents and undertake risk assessments. The inquest heard evidence that support workers need more focussed training on mental health conditions and how to manage and help residents with enduring mental health conditions.
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 29 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 and to the following Interested Persons: Mr Lynch's family West Midlands Police 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	**4 March 2025** Signature:  **Louise Hunt** **Senior Coroner for Birmingham and Solihull**