



RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

When a coroner sends a prevention of future deaths (PFD) report to a person or organisation, they must respond within 56 days. Recipients of a PFD report can apply to the coroner for an extension. A response to a PFD report must detail the action taken or to be taken, whether in response to the report or otherwise, or it must explain why no action is proposed.

The purpose of the response template below is to promote clarity, ensure that responses address the coroner's concerns directly and transparently, and support consistency and good practice across organisations and sectors. It does not restrict how a person or organisation formulates their response; recipients remain responsible for determining what action is appropriate and for ensuring that their response accurately reflects the steps taken or planned.

In accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#) representations regarding publication of a response should be sent to the coroner. These representations should be made at the same time as the response is provided. The coroner will pass any representations received to the Chief Coroner for a decision

	<p style="text-align: center;">RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS</p> <p style="text-align: center;">REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013</p> <p style="text-align: center;">(Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026))</p> <p>THIS RESPONSE IS BEING SENT TO:</p> <p>HM SENIOR Coroner Louise Hunt for Birmingham and Solihull in response to a 'REPORT TO PREVENT FUTURE DEATH REGULATION 28' following an inquest into the death of Keifer Fraser-Philips that concluded on 15 April 2026.</p>
1	<p>RESPONDENT</p> <p>In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, Birmingham and Solihull Mental Health NHS Trust provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths</p>
2	<p>DATE OF RESPONSE</p> <p>9 June 2026</p>

CONFIRMATION OF CORONER'S MATTERS OF CONCERN

The **MATTERS OF CONCERN** were identified in the report as follows:

1. Staff had not been completing the comments section during therapeutic observations as the electronic device they used would drop Wi-Fi signal making it impossible to record the observations until they were back in the ward office. This creates a risk that observations are not being recorded accurately and effectively and creates a risk of future deaths.

2. Many patients with enduring mental health conditions on long term medication will have significant physical health conditions due to the side effects of the medication. These often include considerable weight gain, and in Mr Fraser-Phillips' case sleep apnoea and the associated risk of position asphyxia. There was no care plan in place to address these risks. Consideration needs to be given to ensuring patients with significant physical healthcare needs have adequate care plans in place to address any risks identified.

DETAILS OF ACTION TAKEN, how has the concern been addressed.

(If no action is proposed please explain why here)

Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

Wifi signal on the wards

1. A Survey has now been carried out on a number of the acute wards to understand the extent of the Wifi problems on the wards and ICT are exploring the best solution to resolve the issue where hot spots have been noted. Whilst this might seem like a straightforward problem to solve the ideal solution would be to move the receivers from above the ceilings but due to the nature of the clinical area that creates a ligature risk. Alternatives are currently being explored and the trust and will be tested to ensure efficacy for Wifi, as well as it being clinically safe to use with mitigations in place whilst this is completed.
2. Whilst a more permanent solution is finalised staff have access to desktops and laptops on the ward to input their observations. Staff have also been reminded of the importance of documenting their observations. Staff are being involved to ensure that the solution is sourced as a matter of urgency. I can assure you that the Trust will continue to review this matter until a satisfactory outcome is resolved.

Recording of physical health conditions in care plans.

1. Thank you for raising concerns through the Prevention of Future Death report regarding the management of physical health risks in patients with enduring mental health conditions who are prescribed long-term psychotropic medication.
2. We recognise and fully accept the Coroner's concern that patients with significant physical health conditions arising from, or exacerbated by, their mental health treatment require clear, documented care plans to identify and mitigate risks, including those related to weight gain, sleep apnoea and the associated risk of positional asphyxia. We acknowledge that, in this case, an explicit care plan addressing these risks was not clearly articulated.

Existing Physical Health Assessment and Documentation Systems

3. The Trust utilises the RIO electronic clinical records system, which includes a comprehensive Physical Health Assessment, Systemic Enquiry and Physical Examination form. This structured record, in addition to other comprehensive questions and areas of enquiry, also captures:
 - Current physical health problems
 - Past medical history and long-term conditions
 - Relevant risk factors associated with mental health medication
 - Action Plan sections
 - Follow-up and ongoing management plan sections
4. These sections are designed to prompt clinicians to identify, document and actively manage physical health needs alongside mental health care, and to ensure risks are translated into clear actions and review plans. However, we recognise that the presence of an electronic template alone does not guarantee consistent or effective care planning, and that further assurance is required to ensure physical health risks are clearly addressed and followed through in practice.

Care Planning Improvements: Implementation of Dialog+ Care Planning

5. To strengthen and standardise care planning across inpatient settings, the Trust has recently implemented Dialog+ Care Planning in all inpatient services.

Dialog+ Care Planning provides a structured, patient-centred framework that ensures key domains are proactively explored, agreed and documented during care planning discussions. Importantly, Physical Health is a core Dialog+ domain, alongside mental health, medication, daily activities and safety.

6. This approach supports:
 - Explicit identification of physical health risks linked to medication and comorbidity
 - Collaborative formulation of clear actions to mitigate identified risks
 - Improved visibility of physical health needs within the overall care plan
 - Regular review and updating of agreed actions

We believe this represents a more robust and systematic approach to integrating physical healthcare needs into mental health care planning.

Audit and Assurance Framework

7. In response to the Coroner's concerns, the Trust has strengthened its Audit and Assurance Framework for Dialog+ Care Planning at ward level. This framework includes:
 - Routine ward-level audits of Dialog+ care plans
 - Specific checks that relevant domains are being appropriately used, including the Physical Health domain
 - Assurance that identified physical health risks are clearly reflected in the action plan, with proportionate and documented follow-up arrangements
 - Feedback to clinical teams and incorporation of findings into local quality improvement activity
8. This provides additional governance and oversight to ensure that physical health risks are not only identified but are actively addressed through documented actions and review. This will be further supported by implementation and auditing of the Inpatient MDT standards where senior clinical inpatient staff (including medical and nursing, and

other professionals as appropriate) will be supporting with follow up of any required actions identified in the Physical health action plan.

Learning and Prevention of Future Risk

9. The Trust has shared learning from this case across inpatient teams, emphasising:

- The increased physical health risks associated with long-term psychotropic medication
- The importance of translating physical health assessments into clear, actionable care plans
- The need to explicitly address risks such as sleep apnoea, obesity and positional asphyxia where relevant

10. Combined with enhanced care planning through Dialog+ and strengthened audit arrangements, these actions are intended to reduce the risk of similar omissions occurring in the future and to ensure that patients with significant physical healthcare needs have clear, documented plans to manage identified risks.

11. The Trust is grateful for the opportunity to reflect on this case and remains committed to continuous improvement in the integration of physical and mental healthcare for our patients.

DETAILS OF FURTHER ACTION PROPOSED

Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

During our investigations the Trust has also put into place actions to review the observations on the ward more closely, to ensure a high quality of observations. Monthly audits will now be taking place to review the quality of the observations. Actions will be taken where staff do not comply with policy and results of the audits will be taken to Quality Assurance Group for assurance, to ensure the Trust is providing the best care possible to our in-patients. This will also enable the Trust to monitor not just the quality of the observations but ensure if there are any systemic issues, these are raised and addressed immediately.

SIGNATURE



6

Chief Executive