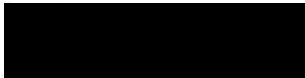


	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p>Birmingham and Solihull Mental Health NHS Foundation Trust</p>
1	<p><b>CORONER</b></p> <p>I am Mrs Louise Hunt Senior Coroner for Birmingham and Solihull</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 25 September 2025 I commenced an investigation into the death of Kiefer Kiam Bolangi Fraser-Phillips. The investigation concluded at the end of the inquest. The conclusion of the inquest was; Natural causes</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Mr Fraser-Phillips had a long history of paranoid schizophrenia with regular relapses and had been under the care of mental health services since 2015 and was an inpatient since 2018. As his condition was treatment resistant, he was managed on clozapine which improved his symptoms. Due to the risk of serious side effects from clozapine he was monitored closely. At the time of his death he was detained under S3 of the Mental health Act 1984 and resided on Magnolia Suite at the Oleaster unit in Birmingham where he had been since May 2024. He was also known to suffer from several physical health conditions included significant weight gain as a side effect of the medication and sleep apnoea. During his time on Magnolia suite he was mostly settled with some ongoing symptoms and plans were being made for his discharge. It took time to find a suitable placement and to secure necessary funding. He was due to start transitioning to supported accommodation on 18/09/25. He was found deceased in bed that morning by staff when they went to wake him at 08.15. He had last been seen alive at around 23.07 the previous evening when he was well. Staff carried out hourly observations throughout the night and staff thought they had seen him breathing in bed when the observations were taken at 07.00 and 08.00. It was clear from his condition when he was found that he had likely passed away when the last observations were undertaken however it cannot be ascertained exactly when he passed away but it was likely within 2 hours of when he was found. Post mortem examination has confirmed he died from sudden unexplained death in schizophrenia.</p> <p>Following a post mortem/Based on information from the Deceased's treating clinicians the medical cause of death was determined to be:</p> <p><b>1a</b> Sudden unexplained death in Schizophrenia  <b>1b</b>  <b>1c</b>  <b>1d</b>  <b>II</b></p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p>

	<p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> </ol>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 10 June 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <p>Mr Phillips' next of kin</p> <p>I have also sent it to the Medical Examiner, ICS, NHS England, CQC, who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.</p>
9	<p><b>15 April 2026</b></p> <p>Signature:  </p> <p><b>Mrs Louise Hunt</b>  <b>HM Senior Coroner for Birmingham and Solihull</b></p>