

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b> NHS England.</p>
1	<p><b>CORONER</b></p> <p>I am James Bennett Assistant 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 21 October 2025 I commenced an investigation into the death of [REDACTED]. The investigation concluded at the end of the inquest on 2 April 2026.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>[REDACTED] had no known mental ill-health and was an experienced Operational Department Practitioner based at Birmingham Children's Hospital. During his shift on 07/10/25 he was informed of a conduct issue. A risk assessment noted he could travel home safely and having family at home was a supportive factor. He was informed he should not come into work the following day whilst a decision was made about an investigation, and that he would be telephoned the following morning with an update. The following morning, on 08/10 around 5:30-6:00am, contrary to instructions, he attended the hospital and accessed a secure drug store and removed anaesthetic medication and intravenous cannula equipment. This was the last known sighting. From 8:45am his employer attempted to contact him via telephone without success to inform him he was to be suspended pending an investigation. Concerns were escalated around 1:30pm that he was a missing person. When it was revealed he had accessed the hospital, a search was undertaken and he was found in the afternoon deceased in a bedroom in on-call accommodation having deliberately injected himself with the anaesthetic. The medical cause of death was confirmed at post-mortem as 1a. Self-injection of [REDACTED]. The conclusion was that death was the consequence of suicide.</p>
5	<p><b>CORONER'S CONCERNS</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><b>The MATTERS OF CONCERN are as follows:</b></p> <p>1. The Trust level investigation identified concerns that NHS England guidance - e.g. (a) NHS England Misconduct Policy 'Every organisation has a duty of care to protect its employees from and prevent incidents of sexual misconduct'; and (b) e-learning 'Understanding Sexual Misconduct in the Workplace' – omits to deal with how to discuss and manage the alleged perpetrator when a member of staff. It does not cover when the Trust may need to conduct a risk assessment of the likely impact on the staff member of being confronted with a serious allegation, when they may need to inform the police promptly, or advise on what factors impact the need for a prompt decision on suspension and withdrawal of easy access to fatal drugs. Since this incident the local Trust has updated their policies so that a same day decision is made on these matters and in a similar incident in the future it is likely the staff member would have been immediately suspended and had their access to fatal drugs removed. My concern is that NHS England guidance continues to omit such considerations and at a local level Trusts are not fully assessing the risks.</p>

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 24 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> <ol style="list-style-type: none"> <li>1. Family of [REDACTED]</li> <li>2. Birmingham Women's and Children's NHS Foundation Trust.</li> </ol> <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>29 April 2026</b></p> <p><b>Signature:</b></p> <p>[REDACTED]</p> <p><b>James Bennett Assistant Coroner for Birmingham and Solihull</b></p>