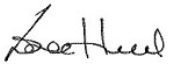
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. G4S** **2. Birmingham and Solihull NHS Foundation Trust** **3. HMPPS** **4. Chief Constable for West Midlands Police** **5. Swansea Bay University Health Board**
1	**CORONER** I am Mrs Louise Hunt for Birmingham and 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 9 September 2020 I commenced an investigation into the death of Jacob Michael Nicholas BILLINGTON. The investigation concluded at the end of the inquest. The conclusion of the inquest was; Unlawfully killed
4	**CIRCUMSTANCES OF THE DEATH** Jacob was unlawfully killed when he was stabbed in the neck on 06/09/20 whilst on a night out in Birmingham with friends. A number of other people were also seriously injured that night by the same perpetrator over a 90 minute period. At the time of the attack the perpetrator was suffering from paranoid schizophrenia a severe and enduring mental illness which was characterised by him constantly hearing voices which at times told him to harm others including 'kill em stab em'. The perpetrator had not been receiving regular prescribed anti-psychotic medication in the months leading up to attack and he also may have taken illicit drugs, both of which may have contributed to the deterioration his mental state. On 22 April 2020 the perpetrator had been released from prison at the end of a three year sentence for drug and firearm offences. He had a long history of violent offending and was known to be a high risk of harm to the public and to have sporadic compliance with anti-psychotic medication, but there was no lawfully available control that might have been placed upon on him at the end of his sentence to protect the public from the recognised high risk he presented. The perpetrator had a long history of refusing to engage with agencies whilst in prison. Although he had been in the community on licence under MAPPA (Multi Agency Public Protection Arrangements) he was recalled to prison on 24/12/18. Shortly after his transfer to HMP Parc on 12/9/19 the MAPPA oversight was prematurely ended without any plan in place aimed at ensuring a co-ordinated release from prison and some of the actions that were prescribed by MAPPA relating to liaison with his local CMHT were not completed. The MAPPA process did not effectively promote risk reduction as it discharged him without plans being in place for a coordinated approach to the care of the perpetrator in prison or to ensure interagency planning for his release. The secondary mental health services In Reach team at HMP Parc failed to conduct a risk assessment or devise any care plan or risk management plan, and there was an absence of adequate coordination between all the numerous agencies involved with him in respect of resettlement and release planning. It was known by 10 March 2020 that a requested resettlement in Wrexham was not going ahead and on 3 April 2020 that he was returning to Birmingham with no

	fixed address. This was not communicated to the relevant agencies including the Birmingham CMHT. On release on 22 April 2020 the perpetrator requested a travel warrant to Birmingham where he lived until the events of 06 September 2020 which was also not communicated. He was released without any support in place for his serious mental illness. By the time the Birmingham CMHT identified in June 2020 where he had moved to on leaving prison he had recently changed address and establishing his whereabouts was not pursued by the CMHT until after he had presented to a new GP on 10th August 2020 asking to be prescribed anti-psychotic medication and after a new care coordinator was in place. He was then seen, on the doorstep of his home on 03 September 2020 by a CPN when he declined to attend a pre-arranged appointment with the CMHT consultant psychiatrist who already knew him from an assessment undertaken in December 2018, but he did agree to have a short telephone conversation with that psychiatrist. A limited assessment was undertaken and it was reasonably planned to instruct the GP to restart him on medication and to review him in the clinic in several weeks' time. It is not known whether he received or took any medication. Three days later the perpetrator attacked several wholly innocent members of the public in Birmingham City Centre and it was during these attacks that Jacob was killed. The failure to adequately manage his release to Birmingham and the failure to ensure the CMHT were notified of his release resulted in a lost opportunity to assertively manage his serious mental health condition and this possibly contributed to his mental state on 06/09/20. Whilst it cannot be said that he probably would have then complied with treatment offered for his significant mental health needs there is a realistic possibility that he would have done so. Following a post mortem/Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a** SHARP FORCE NECK TRAUMA **1b** **1c** **II**
5	**<u>CORONER'S CONCERNS</u>** 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. – 1. **Management of release and lack of interagency working**. The management of the perpetrators release was not coordinated and there was inadequate communication between relevant agencies. In effect agencies worked in silos. Critical information is not being shared and agencies work in different IT systems meaning there is no one place where information is collated and hence a comprehensive account of matters known to each agency is not easily available to those professionals who may need to know a high risk prisoner's whereabouts on release. This concern was reinforced by evidence heard during the inquest that changes made since Jacob's death did not include resettlement information being given to Mental Health In reach teams in the prison. The failure to share information leads to a concern of future deaths as high risk seriously unwell prisoners may be released without key agencies knowing where they are meaning they are not traced and treated assertively in the community. 2. **Systmone** Details of the perpetrators GP and local CMHT were not recorded in an easily accessible format. The format in which key information is recorded has now been amended at HMP Swansea to ensure the prisoner's GP details and their CMHT's details (if a person is an existing patient under a CMHT) are highlighted on a front screen/page. I was informed that this change in information management and presentation within Systmone is

	unique to HMP Swansea and is not the practice in other prisons. I am concerned that there remains a risk that staff treating patients in prison may not have easy access to (and so overlook) this key information. 3. **Cross agency guidance regarding release of high risk prisoners with mental health difficulties at their sentence end date.** There are no provisions available nor any cross agency guidance in place for when a high-risk prisoner is released at sentence end date to ensure that there is adequate release planning and maximum support in the community. 4. **West Midlands MAPPA** has a prison discharge coordinator role. It was clear from the evidence at the inquest that this role was not fully understood by other agencies and what information needed to be shared was not clear. The new policy drafted by BSMHT remained confused as to which cases were to fall within the responsibility of the prison discharge coordinator role. There remains a risk of further deaths as the role is not properly understood and information sharing is not effective.
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 8 May 2024. 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: 1. Jacob's Family 2. Midlands Partnership University NHS Foundation Trust for MHIT 3. Shropshire Community Health NHS Trust the MHIT 4. Forward Thinking Birmingham 5. [redacted], through his solicitors 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	**13 March 2024** Signature:  **Mrs Louise Hunt** **Senior Coroner for Birmingham and Solihull**