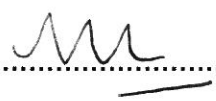
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted] Managing Partner of the Beeston Health Centre, Leeds**
1	**CORONER** I am MELANIE J. WILLIAMSON, Assistant Coroner for West Yorkshire (Eastern District).
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	**INQUEST** On the 19th September 2012 an Inquest was opened into the death of JILL FELICITY SINSON, aged 51 years (D.O.B. 3.6.61) ("the Deceased"). The Inquest was concluded on the 23rd August 2013. The Conclusion of the Inquest was that the cause of the Deceased's death was unascertained and an Open Conclusion was recorded.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased suffered from schizophrenia and an anxiety-related disorder. The Deceased experienced non-epileptic seizures. She was prescribed medication for her mental health condition. She had a history of self- harm and of exhibiting suicidal tendencies. The Deceased was under the care of the Community Mental Health Team ("CMHT") provided by Leeds Partnerships NHS Foundation Trust. On the 10th May 2011 the Deceased moved to Flat 17 at Bewerley Croft Transitional Housing Unit at Northcote Drive in Leeds, which Unit was established by Leeds City Council and which provides tenanted accommodation for adults, all of whom suffer from mental health problems, for the purposes of promoting an independent living environment. Each tenant is allocated one/more key worker(s)/care assistant(s). It was agreed that the Deceased would have contact with her key workers, with a CMHT nurse and with a CMHT Consultant Psychiatrist on a regular basis. The Deceased was last seen alive at around 4pm on the 3rd September 2012. At approximately 5.30pm on the 10th September 2012 she was discovered in a lifeless condition in her bedroom at her said home address. Life was pronounced extinct by attending paramedics at the scene at 1825 hours the same day.
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. –

	(1) The Deceased's General Practitioner did not ensure the Deceased was monitored regularly, or at all, by a General Practitioner but preferred to rely upon the care she received from the CMHT. (2) When the Deceased was seen at the GP surgery by a Staff Nurse on the 3rd July 2012 – (a) the Deceased's presentation on that occasion was such as to necessitate a review by a GP and/or referral to the Deceased's Consultant Psychiatrist, but no such review and/or referral was considered, and (b) due regard was not paid to the Deceased's computerised medical records prior to and/or in the course of consulting with the Deceased on that occasion, as information provided by the Deceased to the said Staff Nurse was fundamentally incorrect which was apparent from earlier entries in the Deceased's said records (3) The Deceased was prescribed a significant quantity of medication on a monthly basis, such medication being given in possession and unsupervised, without due consideration for the Deceased's medical history of self-harm and suicidal tendencies, which history was recorded on the Deceased's computerised medical records. (4) Upon receipt of correspondence from the Deceased's Consultant Psychiatrist, due regard was not paid to the contents thereof and appropriate action was not taken.
	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 the 18th October 2013. 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 this report to the Chief Coroner and to Mr Derek Winter, H M Senior Coroner for the City of Sunderland. 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	**Dated this 23rd day of August 2013**  ..... **MELANIE JANE WILLIAMSON** **Assistant Coroner** **West Yorkshire (Eastern)**