IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Frances Claire ANDRADE
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: 1. The Director of Public Prosecutions in relation to paragraphs 5(1) & (2). 2. The Chief Executive of the Surrey and Borders Partnership NHS Foundation Trust in relation to paragraph 5(3).
1	**CORONER** Richard Travers HM Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into **Mrs Andrade's** death was opened on the 13th January 2013 and was resumed on 7th July 2014. It was concluded on 25th July 2014. The cause of death was: 1a – An acute overdose of fluoxetine and insulin. The conclusion was: Francis Claire Andrade died from an overdose of fluoxetine and insulin but her intention for taking that overdose was unclear.
4	**CIRCUMSTANCES OF THE DEATH** In the summer of 2011 a friend and colleague of Mrs Andrade made a report to the police alleging that Mrs Andrade had been sexually abused as a child and more particularly as a young teenager whilst attending the Cheethams School of Music in Manchester. Mrs Andrade had not agreed to the report being made and, therefore, found herself in a position that was not of her own making. She was interviewed by the police in July 2011 and again in December 2011. From about the date of the first interview she required anti-depressant medication. Prior to that event, she had not required such medication. In April 2012 she took the first of a number of overdoses. This coincided

with the date at which the allegations and the fact that the matter was to go to trail first appeared in the national press.

Evidence was given by a number of witnesses that Mrs Andrade had reported that she had been told by the police that she should not be receiving counselling or psychiatric support as it might adversely affect her evidence at trial. That assertion was not supported by any direct evidence. Rather, there was evidence that an officer from the Greater Manchester Police had put her in touch with RASASC (a local support charity for those who have suffered sexual abuse and rape). Nevertheless, it was apparent that as far as Mrs Andrade was concerned, this issue was a cause of uncertainty and anxiety.

[redacted] agave evidence that in the twelve month period prior to the trial his wife's character / demeanour changed dramatically; on his account she became very introverted and depressed.

There followed a number of further overdoses which became increasingly more serious as the date of the trial (January 2013) approached.

An assessment in late October 2012 by an Occupational Therapist from the Guildford Community Mental Health Recovery Service ('GCMHRS') was followed by a multi-disciplinary team meeting on the 5th November 2012 at which Mrs Andrade was put forward for a care coordinator which, significantly, she agreed to and she was zoned 'red' (urgent). The zoning was recorded incorrectly as 'amber', but despite the fact that that mistake was recognised in the first half of December 2012, the fact that there was a serious intervening overdose (14th December 2012) and the fact that a psychiatric assessment (19th December 2012), noted that she had been referred for urgent care coordination, Mrs Andrade was not allocated a care coordinator until the 2nd January 2013 and then the person who was allocated to her was off sick with no known date for his return. By the time of her death on 24th January 2013 a care coordinator had still not been allocated.

Mrs Andrade gave evidence at the trail in Manchester on the 14th and 15th January 2013.

On the day before she died, the learned trial judge, in response to submissions from counsel, directed that not guilty verdicts should be entered on various counts on the indictment. Those submissions were based upon issues of law that did not relate to the credibility or reliability of Mrs Andrade's evidence. The not guilty verdicts were reported in the media, but no explanation in this regard was given to Mrs Andrade.

She was found in her bed by her husband the following morning; there were no signs of life and death was confirmed by the paramedics on their attendance a short while later.

She was found to have taken an overdose of both fluoxetine and insulin. The insulin which she had used was prescribed to her husband and had

	been kept in the fridge at the family home. Despite the fact that this was the fourth overdose in which she had used her husband's prescribed medication (insulin) no real or effective steps had been taken by those charged with providing psychiatric care to Mrs Andrade to secure that medication with a view to restricting her access to it. Evidence from the new service Manager at the GCMHRS set out in detail changes which had been instigated in the Service since Mrs Andrade's death.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters that gave rise to concerns that circumstances creating a risk of other deaths will continue to exist in the future unless action is taken. The **MATTERS OF CONCERN** are as follows. – 1. Consideration should be given to instituting measures that will ensure that clear and unequivocal advice is given to a vulnerable witness in relation to the obtaining of psychiatric counselling in relation to issues arising from evidence which they will be giving in forthcoming criminal proceedings. 2. Consideration should be given to instituting measures that will ensure that complainants in criminal trials are given a full and timely explanation as to the directions given by a trial judge in relation to counts on an indictment following the receipt of submissions of there being no case to answer in respect of those counts. 3. Where there is a history of overdoses being taken by family member A using medication that is prescribed to family member B, consideration should be given to what steps could reasonably be taken to secure that medication with a view to restricting access to it by family member A.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Director of Public Prosecutions and the Chief Executive of the SABP NHS Foundation Trust have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

	Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following Interested Persons in the Inquest and to the Chief Coroner. 1. [redacted] 2. The Greater Manchester Police 3. The Surrey Police 4. CPS Northwest 5. SABP NHS Foundation Trust 6. [redacted]
9	**Signed:** *Richard Travers* **DATED this 28th day of July 2014**