Nicola Jane Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted] Director Of Quality And Nursing** NHS England Oak House Moorhead Way Bramley Rotherham S66 1YY
1	**CORONER** I am Nicola Jane Mundy, Senior Coroner for South Yorkshire (East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 13/08/2014 I commenced an investigation into the death of Colin Tyson, 51 . The investigation concluded at the end of the inquest on 10 February 2015. The conclusion of the inquest was Suicide. The cause of death was: 1a. Severe, extensive external and internal injuries and fractures 1b. Railway collision
4	**CIRCUMSTANCES OF THE DEATH** Mr Tyson was a private man who had being significantly affected by a physical injury that had limited both his ability to enjoy his sports, for which he had a real passion, and had also led to him being off work for quite some time which was significant for a man who had such a strong work ethic. It was clear that he was struggling to deal with these issues and his perception as to how others might now be viewing him. He attempted to end his life on the 6th August 2014 by way of carbon monoxide poisoning from his car but was taken to hospital and resuscitated. A mental health assessment took place in hospital where he denied further suicidal ideation. An assessment by the general practitioner of the 7th August led to him again being assessed as not requiring any acute psychiatric input. Accordingly no referral was made to the psychiatric services at this time. It became clear during the course of the evidence from family members that Mr Tyson continued to harbour thoughts of suicide and had even been planning how he might do this. On the 11th August 2014 Mr Tyson stepped in front of a high speed train, dying instantly as a result of the impact. The family expressed grave concerns regarding their efforts to pass on information to the GP in the community when they tried to express their concerns to the GP. The concern from the GP practice related to patient confidentiality issues. I am quite satisfied that the family members did have pertinent information which would have benefitted the GP in his assessments. There is a need for there to be a way in which concerned family members of vulnerable persons (even if not falling under the usual category of a child or an elderly patient/person) should be able to pass on relevant information to the general practitioner. Whilst I am not convinced this would have altered the outcome in Mr Tyson's case it may well make all the difference in some cases where persons are in a particularly vulnerable state due to life events at that time. The general practitioner [redacted] shared those concerns and was taking matters back to his private practice but as I felt this raised wider issues for many GP practices ie where GPs might interpret patient confidentiality to extend to not being able to receive critical information. I wish to draw these matters to your attention.

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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) Concern regarding GPs interpretation of patient confidentiality preventing concerned family members passing pertinent information regarding vulnerable persons who are potentially at risk of suicide.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [redacted], Director Of Quality and Nursing 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 07 April 2015. 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 [redacted] I have also sent it to [redacted] and South West Yorkshire Partnership. 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 04 March 2015 [redacted] Signature_____ Senior Coroner for South Yorkshire (East District)

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