IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Christopher John Stubbs
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: [redacted] **– Wibsey & Queensbury Medical Practice**
1	**CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 30 July 2015 I opened an inquest into the death of Christopher John Stubbs who, at the date of his death, was aged 36 years old. The inquest was resumed and concluded on 20 February 2016 I found that the cause of death to be: - 1a. Hanging I arrived at a conclusion of suicide.
4	**CIRCUMSTANCES OF THE DEATH** On 26 July 2015 Christopher John Stubbs, who had a history of mental ill health and drug misuse and a previous attempt to take his own life by drug overdose on 7 February 2015, was found suspended from a ligature made from a bath robe cord attached to a door on the landing of his home address. It was found that he intended to take his own life.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest I heard that Christopher's prescribed medication of mirtazapine and pregabalin was stopped by the acute

	hospital doctors on his discharge from the hospital following his overdose of 7 February 2015, pending a further review by his GP, which I heard did not take place prior to his death. The **MATTER OF CONCERN** is as follows. – • To review the effectiveness of existing office systems and procedures in relation to the receipt of discharge summaries from hospitals which advise on the review of patient's medication.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Wibsey & Queensbury Medical Practice has 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: • [redacted] (mother) • Bradford District Care NHS Foundation Trust • NHS England • Chief Coroner
9	**DATED this 3rd March 2016** **M. D. Fleming** **Senior Coroner**