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

The Inquests Touching the Death of Kathleen Gabrielle Bamforth
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: **Secretary of State for Health and Social Care**
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 24/8/17 I opened an inquest into the death of **Kathleen Gabrielle Bamforth** who, at the date of her death was aged 59 years old. The inquest was resumed and concluded on 12/6/18 I found that the cause of death to be: - 1a. The effects of clomipramine Toxicity I concluded with a narrative conclusion as follows: On 28/5/17, Kathleen Gabrielle Bamforth, who had a history of depression and alcohol misuse, was found to have died at her home address. At post mortem her blood was found to contain fatal quantities of her prescribed medication clomipramine (3.1 ug/ml) along with therapeutic amounts of her prescribed naproxen (21.2ug/ml), tramadol (0.87 ug/ml) and pregabalin (2.3 ug/ml. Although there is no evidence to suggest that she took an overdose deliberately or inadvertently, the reason for the toxicity of the clomipramine toxicity remains unclear

4	**CIRCUMSTANCES OF THE DEATH** At approximately 5.40am 28/5/17, Kathleen Bamforth was found unresponsive in the living room of her home address. Immediate attempts were made to resuscitate her, but upon the arrival of the paramedics she was confirmed to have passed away. She had been prescribed clomipramine for several years by her GP which was being properly monitored although the GP had no clinical cause to check the levels by way of a blood test. During the inquest [redacted] the toxicologist gave evidence and he was unable to confirm whether the toxicity was acute or chronic and that the circumstances of how she developed the toxicity remained unclear.
5	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is as follows. – • To review current practice guidelines with respect to the prescription of clomipramine • To consider the merits of routine blood screens in patients prescribed with long term use of clomipramine.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Secretary of State for Health has the powers to do this.
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: South West Yorkshire Partnership NHS Foundation Trust

8	**COPIES** I have sent a copy of this report to: • [redacted] – Husband • [redacted] - Daughter • [redacted] Tunstall • Chief Coroner • NHS England	
9	**DATED this 20/7/18**	**HM Senior Coroner** **M.D. Fleming**