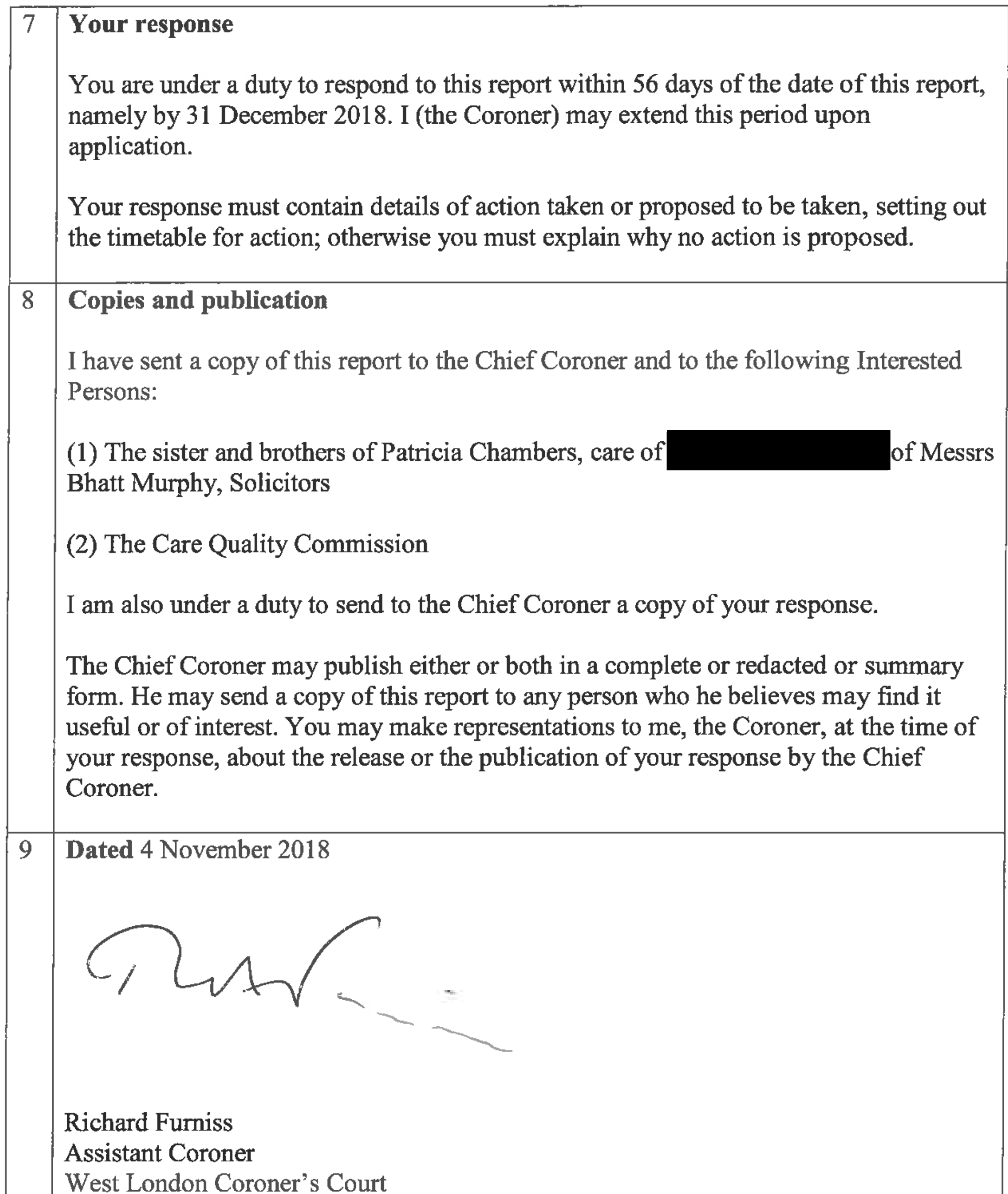
	REGULATION 28: REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: (1) [redacted] on behalf of the WEST LONDON MENTAL HEALTH TRUST (2) [redacted] of the SHEPHERDS BUSH MEDICAL CENTRE (3) [redacted] of the SHEPHERDS BUSH MEDICAL CENTRE
1	**Coroner** I am Richard Furniss, Assistant Coroner for the Coroner's Area of West London.
2	**Coroner's Legal Powers** I make this report under Paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Rules 2013.
3	**Investigation and Inquest** On 13 May 2016, an investigation was commenced into the death of PATRICIA PRISCILLA CHAMBERS, born on 8 February 1965. The investigation concluded at the end of the inquest heard before a jury between 15 and 23 October 2018.
4	**Circumstances of the Death** On 11 May 2016, Patricia Chambers died by suicide contributed to by neglect. She had not recently taken her antipsychotic medication risperdione, and had recently used cannabis. She climbed over the balcony of the communal walkway on the ninth floor of Tom Williams House, where she lived, and jumped to the ground. She sustained multiple injuries which were non-survivable. Intervention by the Metropolitan Police Service before she jumped could not prevent her death. The West London Mental Health Trust operates and is responsible for the Hammersmith and Fulham Mental Health Unit. Patricia Chambers had been an in-patient in the Unit in March 2016. The jury found that the discharge process in March 2016 had been incomplete and inadequate in the following respects: A. A final risk assessment was not completed prior to her discharge from the ward. B. The discharge medication summary form was not completed accurately in respect of prescription instructions for the GP. C. The meeting in respect of the discharge did not follow best practice guidelines and did not include Community Mental Health Team or family members.

	D. The "seven-day follow-up" recorded was inadequate and prevented effective follow-up care. E. The discharge from the ward was not communicated to the CMHT and this absence of communication led to a lack of access to her prescribed drugs. F. Consistent continuity of care, both in terms of appropriate contact with CMHT or GP and subsequent application of prescriptions, was lacking due to Patricia Chambers's discharge having not been communicated appropriately. [redacted] are the two partners operating as the Shepherds Bush Medical Centre, which was Patricia Chambers's General Practice. The jury found that the following indirect factors contributed to Patricia Chambers's death: A. Patricia Chambers's GP failed to maintain complete and timely records. B. The GP's process of document control was non-systematic and unsatisfactory in this case.
5	**Coroner's Concerns: West London Mental Health Trust** The evidence during the course of the inquest revealed matters of concern, which were reflected in the jury's conclusions. In my opinion, there is a risk of future deaths which may be prevented if appropriate action is taken. In the circumstances, it is my statutory duty to report to the West London Mental Health Trust. I heard in the course of the inquest evidence from [redacted] has since February 2018 been the Head of Operations for Access & Urgent Care for the Trust. I address this report directly to her on the basis that she seems to me to be the person who has both sufficient seniority and sufficient proximity to operational matters to take action (or supervise the taking of action). I acknowledge that the Trust carried out a Serious Incident Review under the chairmanship of [redacted] which was critical of the Trust in the circumstances of Patricia Chambers's death. An action plan was then created and [redacted] explained in evidence (which I accept) the various effective steps which have now been taken. I have since heard, through counsel, that the Trust has reflected on the evidence and the jury's findings, and accepts that there is still concern in respect of: - The Discharge Medication Summary ("the Summary") and the 7-Day Follow-Up, which need to be redrawn - Communication of the Summary to other parties (in particular the CMHT, the GP and Pharmacy) - Consistency of the Summary with C2, the Care Programme Approach Policy (which policy, I understand, is itself currently under review)

	- Compliance of the CPA with the Code of Practice (in particular paragraph 34.11 of the Code of Practice) - The appointment, training and supervision of the role of Primary Nurse on the Ward. These reflect my own concerns and are the Matters of Concern for the purposes of this report. **Coroner's Concerns: Shepherds Bush Medical Centre** The evidence during the course of the inquest revealed matters of concern, which were reflected in the jury's conclusions. In my opinion, there is a risk of future deaths which may be prevented if appropriate action is taken. In the circumstances, it is my statutory duty to report to [redacted] The jury has found that your Practice's record keeping was inadequate in 2016, and this was a contributory factor to Patricia Chambers's death. In evidence, [redacted] told the court that the Practice has an "admin team", that records are computerised, and that communications are now made by email and no longer by fax. However, I remain concerned because [redacted] disclosure of records to the inquest was most unsatisfactory. Documents were disclosed in a random, rather than a chronological, order. Important documents were missing from the disclosure, including in particular the Summary referred to above as well as communications to you from the consultant psychiatrist in the community, [redacted] I am concerned that these were received but have been lost. Moreover, [redacted] was unable to give any satisfactory explanation in evidence for the fact that documents were missing and disordered. I am concerned that the system in place for the collection, recording, saving and dissemination of information within the Practice is unsatisfactory, and that this could lead to information being lost and/or ignored, with a consequent risk that future deaths could occur unless action is taken.
6	**Action should be taken** In my opinion, action should be taken in respect of the Matters of Concern set out above in respect of West London Mental Health Trust, and such action may prevent future deaths. I believe that the West London Mental Health Trust, via [redacted] has the power to take such action. In my opinion, action should be taken in respect of the matters set out above in respect of the Shepherds Bush Medical Centre,and such action may prevent future deaths. I believe that [redacted] 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 31 December 2018. I (the Coroner) may extend this period upon application. 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 the following Interested Persons: (1) The sister and brothers of Patricia Chambers, care of [redacted] of Messrs Bhatt Murphy, Solicitors (2) The Care Quality Commission I am also under a duty to send to 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** 4 November 2018 Richard Furniss Assistant Coroner West London Coroner's Court