Mrs. C.E. Mason
Senior Coroner for Leicester (City and South)

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: Mr Simon Stevens , Chief Executive, NHS England** |
| 1 | **CORONER**<br><br>I am Mrs. C.E. Mason, Senior Coroner for Leicester (City and South) |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 27/03/2014 I commenced an investigation into the death of Simion Costin, 39. The cause of death was - Incised wound to the neck<br><br>The investigation concluded at the end of the inquest on 24 February 2015. The conclusion of the inquest was "Took his own life while his mind was in a state of imbalance" |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>Simion Costin died at the Leicester Royal Infirmary on the 25th March 2014 after being admitted with a self-inflicted neck incision. Mr Costin had attended the hospital on two occasions in the preceding 4 days. On both occasions he had been discharged after mental health assessment. On the second occasion an opinion and discharge plan was made on incomplete data. As a result there was a missed opportunity for things to have been done differently and the chance of a better outcome was lost. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) Evidence was heard that during patient assessment, the same approach was not adopted by all clinicians. As a result standardised assessments forms have now been developed and are being used within the Leicestershire Partnership Trust. This includes the need to involve family / friends in the assessment (with the consent of the patient). However, it was recognised that mental health care often crosses boarders with an initial assessment made in a neighbouring hospital but then the patient transferred for care and treatment elsewhere. The Consultant gave evidence that it would be better if there were nationally agreed standard forms so that communication in these complex situations is best served. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 21 April 2015. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br>[redacted]<br>Leicestershire Partnership Trust<br>Care Quality Commission<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 26 February 2015<br><br>[redacted]<br>Signature<br>Senior Coroner for Leicester (City and South) |

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