REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, Greater Manchester West Mental Health NHS Foundation Trust.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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
3	**INVESTIGATION and INQUEST** On 8th October 2014 I commenced an investigation into the death of **LEAH LEVINE** dob 18th February 1965.The investigation concluded on the 27th February 2015 and an Open Conclusion was recorded. The medical cause of death was 1a Multiple Injuries.
4	**CIRCUMSTANCES OF THE DEATH On the 5th October 2014 she was staying with a Rabbi friend when she got through a window on to the roof of the house and then either jumped or fell to her death.**
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 MATTER OF CONCERN is as follows. –** **When it was negotiated by the family and friends, with the NHS Trust employees, that she could have temporary leave from the hospital, it was never clearly set out as to what the conditions of that leave should be: who should be responsible for supervising her: What the level and frequency of such supervision should be: what, if any, observation regime should be put in place: and nothing was reduced to writing and given to those taking her from the hospital.** **Consequent on the above, there was conflicting evidence from different members of the medical and nursing staff as to what exactly was expected and put forward as required.**
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.** **Urgent consideration should be given to putting in place a requirement for such**

	home leave requirements always to be set out in writing and a copy be given at the time to the person having care of the patient whilst on leave.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th May 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 namely [redacted] (mother of the deceased) and [redacted] (sister of the deceased). I have also sent a copy to the **Care Quality Commission** who may find it of interest. 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	**11.3.15** [redacted] **John Pollard, HM Senior Coroner**