ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Medical Director and Dr Sara Munro, Chief Executive of the Leeds and York Partnership NHS Foundation Trust**
1	**CORONER** I am David Hinchliff, Senior Coroner, for the Eastern Coroner Area of West Yorkshire.
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 2nd December 2015 I commenced an investigation into the death of Michaela Louise Thompson, age 36. The investigation concluded at the end of the Inquest on 19th October 2016. The conclusion of the Inquest was a Narrative, a copy of which I attach. The medical cause of death was:- 1(a) Hanging
4	**CIRCUMSTANCES OF THE DEATH** The deceased was separated from her husband and lived with her two children aged 5 and 10, and had a medical history of suffering with depression. Mrs Thompson believed that she was suffering with a borderline personality disorder and/or bipolar disorder. These conditions had not been formally diagnosed. Miss Thompson had a long association with mental health services and was fully compliant with all treatment options. She had not been seen by a psychiatrist nor had any mental health assessment. She had regular suicidal thought culminating in her taking her own life by an act of self-suspension at her home address, her death being confirmed there at 1724 hours on 1st December 2015.
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 **MATTERS OF CONCERN** are as follows. – (1) Michaela was the subject of two multi-disciplinary team meetings which were inadequately documented in the case notes. It should be clearly documented as to who was present and participating in such meetings. The identification of those involved should be clearly recorded, as should the outcome of and decisions made at such meetings. (2) On the morning that Michaela Thompson died, she had telephoned Aire Court in the

	presence of a friend who noticed that she became anxious and upset during that brief call. There was no record kept as to the nature of the call or any information or advice given, nor was the fact of the call immediately communicated to the Community Mental Health Nurse involved. Calls to the Service should therefore be recorded, to ensure that details of the nature of the call; its urgency; and the action taken by a named individual or individuals can be clearly ascertained.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 28th December 2016. 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, Messrs Slater and Gordon Solicitors (representing the family), Messrs DAC Beachcroft LLP (representing Leeds and York Partnership NHS Foundation Trust) and Messrs Capsticks Solicitors LLP [redacted]. 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	**2nd November 2016** **Signed By Coroner:**