MS N J MUNDY
H M CORONER
SOUTH YORKSHIRE (East District)

email: [redacted]

CORONER'S COURT AND OFFICE
CROWN COURT
COLLEGE ROAD
DONCASTER DN1 3HS

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Sheffield Health Partnership, University NHS Foundation Trust

1. CORONER

I am Ms N J Mundy for South Yorkshire East

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 20 December 2024 I commenced an investigation into the death of Jason Ricardo White. The investigation concluded at the end of the inquest . The conclusion of the inquest was Suicide.

The cause of death was:

1a [redacted]

4. CIRCUMSTANCES OF THE DEATH

Jason Ricardo White developed mental health symptoms in April 2024 which were essentially depression and psychotic episodes. Mr White engaged with both his GP and mental health support services including the Priory hospital in Nottingham, Sheffield Teaching Hospitals NHS Trust, Sheffield Health Partnership University NHS Foundation Trust, and Sheffield City Council to manage his symptoms. He remained fixated on his symptoms being linked to serious medical complaints and appeared at no time to accept that the physical symptomology of which he complained was inextricably linked to his mental health challenges. Mr White received various levels of management which included medication. One of those medications was olanzapine. This was ceased abruptly due to a belief that this was responsible for deranged liver function tests but there was inadequate follow-up thereafter. As it was Mr White died from [redacted] on the 10th of December 2024 [redacted].

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. Antipsychotic medication (Olanzapine) abruptly ceased and the management plan of daily monitoring was not followed.

2. This created a risk of relapse in terms of psychotic symptoms and associated deterioration in mental health.

3. Risks of relapse when any medication is abruptly ceased. Must be fully monitored; the absence of full assessment and monitoring exposes patients to risk of a serious deterioration in mental health.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you, [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 the **13th February 2026**. 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 [redacted], Sheffield City Council and Priory Healthcare.

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.

19 December 2025

9. Signature

[redacted]

Ms N. J . Mundy LL.B (hons)

Senior Coroner for South Yorkshire East