REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive, Pennine Care NHS Trust 2. [redacted] General Practitioner York House Surgery 3. Chief Executive, Rochdale, Heywood & Middleton Clinical Commissioning Group 4. Department of Health, London
1	**CORONER** I am Mrs L J Hashmi, Assistant Coroner, for the coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 21st October 2013 I commenced an investigation into the death of David Gary Chatburn then aged 29 years of 19 Hampden Street, Heywood, Greater Manchester. The investigation was concluded at the end of the inquest on the 3rd March 2014. The conclusion of the inquest was that the deceased took his own life whilst the balance of his mind was disturbed. The medical cause of death being hanging.
4	**CIRCUMSTANCES OF DEATH** The deceased had a long and significant history of mental health problems, including depression. He had a tendency to drink alcohol to excess and his mood could be erratic. Whilst it was believed that the deceased had probably been suffering from bi-polar disorder for some time, it was not until December 2012 that he agreed to consider medical treatment for this illness. The deceased's General Practitioner made the diagnosis. He was not seen or assessed by a Consultant Psychiatrist as the General Practitioner felt he was best placed to diagnose and treat Mr Chatburn. In December 2012, the deceased was commenced on medication (Lamotrigine) – a drug that the GP believed was favoured by the local community psychiatrists. This therapy was prescribed and managed solely by the GP, although it would seem that follow-up/reviews were generally informal/opportunistic rather than pro-active. The deceased's mental health continued to fluctuate. On the 18th October 2013, a dog-walker discovered the deceased hanging from a tree.
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. That there was no referral made by the GP to the Psychiatric services for an expert diagnosis/opinion/management and treatment plan. The GP considered that there was no need, as he felt clinically competent to manage the deceased's care and in any event, had a special interest in mental health, although he conceded that he was not formally recognised as a GP with a Special Interest ('GPwSpi') and whilst confident in his ability to manage the deceased's care, his area of special interest was in fact the management of addictions. Irrespective, he felt that he was best placed to assess, diagnose and treat the deceased on the basis that had he referred Mr Chatburn to the single point of entry system, the person 'triaging" would not have been medically qualified and would not have known the deceased as well as he felt he did. 2. That the GP did not consider the appropriateness of the medication prescribed, particularly in light of the patient's past mental health history - preferring to rely upon the presumed, anecdotal preferences of the community psychiatrists. 3. That the GP was unable to refer the deceased, as a new patient, directly to the in-house community based psychiatrist, thus effectively defeating the object. 4. That the GP felt it was sufficient for him to simply discuss the deceased's care with the practice-based community psychiatrist and thus, no need for a referral to the single point of entry process. Such discussions were not necessarily case specific in any event but rather, general in nature. 5. That the GP's recollection of events was not supported by contemporaneous record keeping, thus calling into question accuracy. 6. That the GP did not use a recognised assessment tool, as an adjunct or otherwise, in his clinical evaluation of the deceased. He felt that they were ineffective and of little, if any, value. 7. That the processes GPs are expected to use in order to access mental health services for their patients are unnecessarily bureaucratic and deterrent. GPs can no longer simply contact a Consultant Psychiatrist directly for advice. Everything must pass through the single point of entry. 8. That the 'triage' process used by the single point of entry system is not always managed by a medically qualified practitioner – this being a vital stage in determining diversion/allocation. 9. That GPs cannot refer patients outside their Clinical Commissioning Group area without special permission/approval by the same. In order to do so, a 'special case' must be argued. This potentially limits patient (and practitioner) accessibility and treatment.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (AND/OR 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 Monday 19th May 2014. I, the Assistant 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 the family of the deceased and the General Medical Council. 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 from. 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	18th March 2014	Signed: