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] **Practice Manager, Mundesley Medical Centre, Munhaven Close, Mundesley, Norwich NR11 8AR** 2. [redacted] **Mundesley Medical Centre, Munhaven Close, Mundesley, Norwich NR11 8AR** 3. [redacted] **Chair, NHS North Norfolk CCG, 1 Mill Close, Aylsham, NR11 6LZ**
1	**CORONER** I am DAVID OSBORNE, assistant coroner, for the coroner area of NORFOLK
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 28 OCTOBER 2013 an investigation was commenced into the death of DARREN LEE ARNOUP, aged 48. The investigation concluded at the end of the inquest on 30 April 2014. The conclusion of the inquest was that Darren Arnoup killed himself and the medical cause of death was 1a Hanging.
4	**CIRCUMSTANCES OF THE DEATH** Police attended the home address of Darren Arnoup on 27 October 2013 following concerns raised for his well being and safety. He was discovered hanging in the garage to the property. He was sadly declared deceased at the scene. Darren had been referred to the Colman Centre for a neuro-psychological assessment in April 2012. It became apparent that he had mental health and alcohol abuse difficulties which would make assessment difficult. He was therefore referred to Norfolk Recovery Partnership and AAT. However the Colman centre continued to have regular contact with Darren and his wife until he was discharged from the Colman Centre in September 2013. He was engaging with NRP regarding his alcohol abuse. The Colman Centre contacted Darren's GP practice, Mundesley Medical Centre, on several occasions, in particular they were provided by way of copy for information with an initial report dated 21 May 2013 and a letter dated 12 June 2013, this being the referral letter requesting both NRP and AAT input. The latter letter made specific reference to concerns regarding Darren's mental health and suicidal ideation and self-harming behaviours.
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. – I read evidence by way of a number of letters written by Darren's GP [redacted] who at the time of the Inquest hearing had retired and was abroad. His evidence was to the effect that he was not aware of any history of suicide attempts or self-harm. His evidence was that the two letters referred to at section 4 of this report were received for information only and he did not read them. He was therefore unaware of their content. I heard evidence from the practice manager of the Mundesley Medical Centre, [redacted] Her evidence was that correspondence received into the practice from external providers was initially reviewed by administration staff who, it was accepted, were not medically qualified in accordance with guidelines issued by the Doctors. It would only be referred to a Doctor if there was within the correspondence a specific request for action, otherwise it would simply be filed or logged onto the electronic SystemOne. The practice manager stated that this was common practice amongst GP surgeries/practices. I heard evidence from [redacted] of the Colman Centre. In her evidence she confirmed that she would have expected the letter of 12 June 2013 to have been read by the GP and noted, even though sent for information only. In the light of that evidence I am concerned that there is a continuing risk that letters containing information about a concern for the suicide risk or self-harming behaviour of a patient will not be noted. Whilst it is not known whether in the case before me had the GP noted the content of the letter the tragic outcome would have been different I can readily envisage situations where it could. I am therefore concerned that guidelines operated by GP practices/surgeries, including the Mundesley Medical Centre may need to be reviewed to ensure that in future correspondence which refers to a concern for the suicide risk or self-harming behaviour of a patient is referred to a Doctor/GP so that the Doctor/GP is aware of the concern.
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 by 26 June 2014. 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] [redacted] Via email [redacted] Via email

	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	**1 May 2014**