REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Department of Health, Richmond House, 79 Whitehall, London.**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner North London
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** Edward Gascoigne died on 8 May 2015, aged 80 years old, from injuries sustained after he was hit by a tube train. An inquest into his death was heard on 29 September 2015, at which I recorded a narrative conclusion (see attached).
4	**CIRCUMSTANCES OF THE DEATH** Mr Gascoigne had a background history of some depressive episodes. In the few weeks before his death he had reported increasing episodes of confusion and low mood. This prompted attendance at his General Practitioners', who started antidepressant medication and referred him to community mental health services. One GP involved in his care also noted that he had stopped taking medication to treat hypothyroidism. Before Mr Gascoigne was seen by the mental health team, he reported a worsening of his symptoms and was admitted to A&E at the Royal Free Hospital. He was noted to have moderate depression and was admitted overnight, for input from the psychiatric liaison team. The admitting doctor noted a more significant history than had been appreciated, including two episodes of suicidal plans, the last being three years previously. Mr Gascoigne denied any current suicidal thoughts or plans. It was not noted that Mr Gascoigne had stopped his thyroid medication, nor that he had been prescribed antidepressants. Neither was it documented that the GP had referred to community psychiatry already. The hospital doctors were not able to access Mr Gascoigne's GP records in order to ascertain this information, which does not appear to have been volunteered by the patient himself. The situation was discussed with the psychiatric liaison team, who advised that Mr Gascoigne be referred to community psychiatry. The Trust providing liaison psychiatry at the Royal Free Hospital was different from the Trust who provided community psychiatry at Mr Gascoigne's home address. As such, they were unable to appreciate that this referral had already been undertaken.

	After being informed that that he was not going to be reviewed by psychiatry as an inpatient, Mr Gascoigne became angry and frustrated. He was formally discharged at this point and shortly afterwards was found deceased at an underground station, having been hit by a train. There was CCTV evidence that no third party was involved in this incident. I heard evidence at the inquest that, had the additional relevant information been available to the psychiatric liaison team, it is probable that Mr Gascoigne would have been reviewed as an inpatient. However, it was also likely that Mr Gascoigne would still have been discharged for review by the community team.
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) Multiple pieces of relevant information regarding Mr Gascoigne's current illness were contained in disparate record 'silos'. It was difficult for clinicians to access this information and, as such, it was not available to the reviewing psychiatric team, in particular. I am concerned that the previous focus on access to medical records, which was to occur through the NHS Programme for IT, has been lost and that the new focus on patient access to GP records will not address the risks posed by the current state of record sharing within the NHS.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the addressee, has 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 2 December 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, Mr Gascoigne's family, Mr Gascoigne's GP and the three NHS Trusts involved. 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	**7 October 2015** **Assistant Coroner R Brittain**