H.M. Coroner, City of London

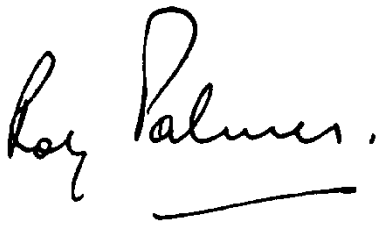
City of London Coroner's Office
Walbrook Wharf, 78-83 Upper Thames Street, London EC4R 3TD

Coroners & Justice Act 2009; The Coroners (Investigations) Regulations 2013 No. 1629
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. Chief Executive, First Response Team, South Essex Partnership University NHS Foundation Trust** **2. Chief Executive NICE**
1	**CORONER** I am Dr Roy Palmer, assistant coroner for the City of 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, No. 1629.
3	**INVESTIGATION and INQUEST** On 21st April 2015 we commenced an investigation into the death of Karen O'Brien born 27th April 1968. The investigation concluded at the end of the inquest on 13th July 2015. The conclusion of the inquest was that Karen O'Brien killed herself. The medical cause of death was Multiple Injuries.
4	**CIRCUMSTANCES OF THE DEATH** Karen O'Brien suffered from chronic pain and depression. A general practitioner (GP) from London Road Surgery had treated her with sertraline and with paroxetine as well as with pain-killing medication. On 4 November 2014 he referred her to the mental Health Crisis Team because of depression and anxiety with somatization and because she admitted to self-harm thoughts. She was also a carer for her father. The GP asked if the Mental Health Crisis Team could see her. On 10 November a community mental health nurse from the First

	Response Team of South Essex Partnership University NHS Foundation Trust (SEPT NHS) replied by letter to the GP that "*based on the information received, we have **clinically** determined a mental health face to face assessment is not required at this stage"*, stating that NICE Guidelines **recommended** that patients are offered two different types of anti-depressants before being referred to secondary mental health services. (**Emphasis added)** On 18th March 2015 the patient registered with Robert Frew Medical Partners and was referred to hospital on 24th March for assessment of a breast lump. On 21st April 2014 Karen O'Brien jumped into the path of an underground train at Liverpool Street station.
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. – It is difficult to understand how there can be a **clinical** determination by SEPT without more inquiry and, preferably, some face-to-face assessment of the patient by a mental health professional. The NICE guidance is stated to be a **recommendation**. It must therefore be presumed not to be applied slavishly without careful assessment. The patient's GP had asked for her to be seen. On what basis did SEPT decide to override the GP's request? If the NICE Guideline has been accurately reported in SEPT's letter to the GP, I respectfully invite NICE to reconsider the guideline.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 11 September 2015. I, the coroner, may extend the period if you so request. 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] (father-in-law) The London Road Surgery, Wickford, Essex Robert Frew Medical Partners, Wickford, Essex 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	**15th July 2015**  **Coroner**