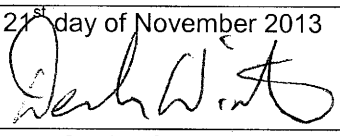
Derek Winter
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Rt Hon Jeremy Hunt** **Secretary of State for Health** **Department of Health** **Richmond House** **79 Whitehall** **London SW1A 2NS**
1	**CORONER** I am Derek Winter, Senior Coroner for the City of Sunderland
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 14/06/2013 I commenced an investigation into the death of Peter Galea. The investigation concluded at the end of the inquest on 20th November 2013. The conclusion of the inquest was that he killed himself.
4	**CIRCUMSTANCES OF THE DEATH** Peter Galea was a 51 year old male, who lived with his mother as her main carer. When his mother had been diagnosed as terminally ill, Mr Galea was unable to cope and his alcohol intake increased. In the morning of 8th June Mr Galea accompanied by his brother attended Cherry Knowle Hospital, being the Mental Health Hospital for the City, and was redirected to the Accident and Emergency Department of Sunderland Royal Hospital, where arrangements were made for a mental health assessment to be undertaken at 10:30hrs. Mr Galea was assessed as low risk and he was given contact numbers of services he could contact for support. Mr Galea also presented to the Emergency Department of Sunderland Royal Hospital on 10th June and was subject to a mental health assessment at 13:45hrs. There was no change from the first assessment. Other referrals were instigated, self help material given and it was noted that Mr Galea had an appointment to see his GP on 11th June at 8:40am. On 11th June at 04:40hrs Mr Galea presented again to Sunderland Royal Hospital and was subject to a third mental health assessment and was assessed as low risk. The plan for him was to see his GP the following day to discuss a possibility of being prescribed appropriate medication. Each of three mental health assessments was faxed to Mr Galea's GP. During the course of the Inquest it became apparent that Mr Galea had been involved with a number of other agencies over this 72 hour period, including the Ambulance Service and Police. It was also the case that Mr Galea had engaged and disengaged from his GP on 10th June.

	Mr Galea had also expressed the view that he wished to be admitted to Cherry Knowle Hospital and although compliant on occasions, he appeared to become frustrated when this did not become a possibility. When Mr Galea attended his GP on 11th June shortly after 8am, he was persistent in his demand to be admitted to Cherry Knowle Hospital. I heard evidence that this was not for the GP's to do, and although Mr Galea was extremely agitated, the GP deployed all of his available skills to try and calm Mr Galea. The GP discussed other options with Mr Galea, including a referral back to the Mental Health Team, prescription of medication and a possibility of the GP contacting the Police to have him removed to a place of safety. No options would be considered by Mr Galea other than going to Cherry Knowle Hospital for admission. Mr Galea threatened to jump from a bridge and left the General Practitioner's surgery. The GP contacted the Police and they conducted a search. Mr Galea's body was found under the Queen Alexandra Bridge on 11th June and he was pronounced dead at 12:51hrs.
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. – Mr Galea was not known to mental health services and experienced multiple presentations to a number of professionals and agencies within a 72 hour period and had 3 mental health assessments, all of which placed him at a low risk. Whilst it is a tragedy that the professionals and agencies did not have more of an opportunity to work with Mr Galea before he took his own life, I was concerned, that: - 1) there appeared to be limited mechanisms available to break the cycle of referrals between agencies without more positive action being taken whereby Mr Galea could be in a safe place whilst a more detailed assessment of his needs could be carried out possibly involving a psychiatrist. The family described the referral between agencies as "ping pong". 2) there were limitations upon the GP making a direct referral to have Mr Galea admitted to Cherry Knowle Hospital, because to do so Mr Galea would have had to go back to the Mental Health Team, with whom he had had three contacts within a 72 hour period. From the evidence it was clear that the GP had a positive relationship with his patient (for 4 years) and although prospectively acquiescing to the patient's wishes, in exceptional circumstances, it may be that a GP should be able to achieve an admission to a place of safety, even if only for a limited period of time. I readily acknowledge some of the disadvantages which may come into play by way of admission but in raising it there may also be advantages which would promote a patient's welfare. 3) I was grateful for the assistance of [redacted] Consultant Psychiatrist, but he was not able to offer to me any view about what may have been done differently for Mr Galea to avoid this very tragic outcome. In raising the matter with you, it may be that some solution to enhance patient's welfare and wellbeing can be found to prevent future deaths.
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 21st January 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: - - Family - City Hospitals Sunderland NHS Foundation Trust - Mental Health Trust and their Solicitors - General Practitioner [redacted] - Regulation 28 Archivist for Coroner Society of England and Wales 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	Dated this 21st day of November 2013 Signature  Senior Coroner for the City of Sunderland