A R W Forrest LLM, FRCP, FRCPath
GMC Number: 1333523
Her Majesty's Senior Coroner for South Lincolnshire

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] Chair – Lincolnshire East CCG** **[redacted]** **2. [redacted] Chief Operating Officer, Lincolnshire East CCG** **[redacted]** **3. [redacted] Chief Nurse, Lincolnshire East CCG** **[redacted]** **4. Professor Sheona Macleod, Director of Education Quality and Post Graduate Dean, East Midlands Local Education and Training Board, 1 Mere Way, Ruddington Fields Business Park, Ruddington, Nottingham, NG11 6JS**
1	**CORONER** I am Paul Cooper, Assistant Coroner for the Coroner's area of South Lincolnshire.
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 8th April 2014 I commenced an investigation into the death of John William THORPE, age 78. The investigation concluded at the end of the inquest on 19TH June 2014. The conclusion of the inquest was SUICIDE.
4	**CIRCUMSTANCES OF THE DEATH** In February 2014 the deceased consulted [redacted] Foundation Year 2 trainee doctor at Swineshead Medical Group Practice, for non-specific symptoms including low

[redacted]

	mood. A variety of investigations were initiated, with no significant pathology being elucidated. He again consulted [redacted] on 12th March 2014 complaining of feeling more tired and with low mood. Feelings of hopelessness and self-harm were elucidated. A PHQ-9 screening test was administered with a score of 16/27 being obtained, indicative of moderately severe depression. Mr Thorpe was given a prescription for 20 milligrams of the anti-depressant fluoxetine daily and asked to self-refer himself to "IAPT" (Improving Access to Psychological Therapies). He was given no firm appointment to be seen again at the practice, but the plan noted in the clinical records was to see him again in 1 months time. On 24th March 2014, Mr Thorpe left his home, taking his dogs for a walk. His dogs were found tethered to a railing adjacent to the Forty Foot Drain, a large drainage dyke, at Swineshead Bridge. Footprints, matching his boots were found tracking down into the dyke and he was found floating in the middle of the dyke. The post mortem indicated that the cause of death was drowning and that he had been taking fluoxetine regularly in the days before his death as well as diphenhydramine.
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 the deceased was asked to "self-refer" himself to IAPT rather than a direct referral being made on his behalf to an appropriate mental health resource. His widow was particularly critical of this at the Inquest, commenting she attempted to fill the form in for him but it wasn't completed and she believed her husband would have responded if a direct referral had been made. I appreciate this may be 'standard practice' but the point is surely not in every case and Doctors should be encouraged to use their discretion more 2 That no intention to follow him up, with a definite appointment being given or by telephone contact, is recorded in the clinical records. 3 That [redacted] knowledge, elicited at the inquest, that "sometimes when

[redacted]

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	anti-depressant is started it can give you more energy" and that Mr Thorpe had a history of a previous suicide attempt was apparently not considered together with the advice in the British National Formulary on suicidal behaviour and treatment with anti-depressants, viz; "the use of anti-depressants has been linked with suicidal thoughts and behaviour; children, young adults and patients with a history of suicidal behaviour are particularly at risk, where necessary patients should be monitored for suicidal behaviour, self-harm, or hostility, particularly at the beginning of treatment or if the dose is changed".
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 **16th September 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: 1. [redacted] 2. Vigilance and Intelligence Research Group, MHRA, O, 151 Buckingham Palace Road, London, SW1W 9SZ 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.

[redacted]

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9	**23rd July 2014** **PS Cooper** ..... **HM Assistant Coroner for South Lincolnshire**

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