	REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Cambridge and Peterborough NHS Foundation Trust ([redacted]** **2. GP practice Orchard Surgery, New Road, Melbourn, SG8 6BX[redacted]** **3. Cambridgeshire and Peterborough CCG, Lockton House, Clarendon Road, Cambridge, CB2 8FH, [redacted]** **4. NHS England, Victoria House, Capital Park, Fulborn, Cambridge, CB21 5XB**
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 13 February 2015 I commenced an investigation into the death of Edward Angus Mallen whose date of birth was 16 December 1996. The investigation concluded at the end of the inquest on 14 June 2016. The medical cause of death was multiple traumatic injuries. The conclusion of the inquest was that Edward's death was due to suicide.
4	**CIRCUMSTANCES OF THE DEATH** Edward Mallen was suffering with depression. He saw his GP on 22 January 2015 and admitted to suicidal thoughts. The GP referred to secondary mental health services. He had telephone contact with the Assessment and Referral Centre ["ARC"] on 23 January and a face to face assessment with two members of the Crisis Resolution and Home Treatment Team on 26 January After the ARC call the GP prescribed anti-depressant medication. Edward saw a psychologist privately on 6 February due to the frustration the family had with lack of. Nevertheless on Monday 9 February 2015 at around 2015 he alighted from a train at Meldreth station and walked to an area away from the station, lay down across the line and was struck by a train.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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. The GP, [redacted] understood that he had been instructed by a member of the Assessment and Referral Team to prescribe citalopram. The member of staff with whom he spoke was a nurse with no prescriber status. The GP felt bound to follow the advice given seemingly without appreciating that prescribing was his responsibility and with it the obligation to advise the patient about the medication. 2. The trust acknowledges that it would be inappropriate for non psychiatrist members of staff to be advising GPs on medication and that this must be communicated to all staff. 3. Edward received no advice about the contraindications of the medication and critically that he may well feel worse before he felt better and may feel more suicidal. In either event he should have been told who to call to get further assistance. 4. The fact that Edward did not receive this information could be due to there being no clear sense of who would be responsible for his care pending further mental health team appointments. 5. [redacted] did not appear to appreciate that he could ask to speak with a consultant psychiatrist if he had any concerns and wanted to discuss any aspect of care or treatment.

	6. Apparently all GPs should have been made aware by the CCG that there is a duty psychiatrist with whom they can speak but according to the trust many GPs remain unaware of this.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that 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 07 November 2016. 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, GP Practice, CCG, CPFT, NHS England. Similarly, you are 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.
9	**07.09.2016** **Ms B Cheney**