REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Wanstead Place Surgery, 45 Wanstead Place, Wanstead, London E11 2SW**
1	**CORONER** I am Ian Wade QC, Assistant Coroner for the Coroner area of East 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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 20th October 2016 I commenced an investigation into the death of Grant Lincoln RICHARDS (born 30th September 1966) who died on 19th October 2016. The investigation concluded at the end of the inquest on the 20th March 2017. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** Grant Richards had a history of depression for which he was treated. On the 19th October 2016 he made his own way to the tenth floor of his tower block at 22 Gardner Close Leytonstone, opened a window, ejected himself and suffered catastrophic injuries upon striking the ground.
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 Richards previous medical history included diagnoses of depression, and anxiety, for which he was treated at various times pharmacologically, by inpatient treatment in a secure hospital, by access to the Home Treatment Team and by community based mental health care. His history included self-harm and suicide attempt. His anxieties included financial worry, debt, unemployment and eviction. He attended A&E at Whipps Cross Hospital on 23rd July 2016 for treatment of pain in his right loin. Whilst there he was x-rayed to the chest, which revealed a "shadow" on the right side. The hospital advised Mr Richards and his sister who attended with him that this matter would be raised with the GP, and he was informed that the hospital recommended follow-up in the chest clinic. The discharge summary recorded "disch for GP F/Up – to check progress" and also specifically noted the clinician's comments which included "please arrange F/U in the chest clinic". A letter was given to the patient as well as emailed to the GP surgery. The initial GP evidential witness report to the Coroner, prepared for submission

	to the Inquest, made no mention of this event. I heard evidence that the usual surgery protocol was that a reviewing doctor would assess all emailed reports received into the surgery, and in a case like this would instruct the surgery receptionist to contact the patient to arrange an appointment for such follow-up to be actioned. The evidence was that this did not happen. There was no follow-up. When Mr Richards was next seen in surgery on 5th October 2016, the x-rays were not discussed and there was no discussion of the requested follow-up by either the doctor, Mr Richards or his sister. The evidence was that Mr Richards was thought to be alarmed at the prospect that he might have lung cancer, from which his mother had died, and it was possible that this anxiety played a part in the prolongation or exacerbation of his depression leading to his suicide. Additionally, evidence was given that in the course of a Root Cause Serious Incident Investigation conducted by an independent panel at the behest of the mental health authority (North East London Foundation Trust) that documents were sent electronically by fax from agencies of the Trust, especially the home treatment team and/or the Redbridge Access and Assessment Brief Intervention Team, which the GP surgery did not act upon although the Trust had received successful transmission reports generated by the fax machine. The features of: a) failure to act upon the request in the A&E discharge summary; b) failure to have a contingency system or audit in place to ensure that such failures are not missed; c) failure to include reference to the attendance at A&E and the discharge summary generated as a result of it, in the GP evidential report; d) and failure to act on fax documents sent to the surgery, all indicate a want of management control, lack of suitable procedures in place and a poor attention to documents received.
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 **17th May 2017** 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 [redacted] (sister), CQC and Mr Matthew Cole, Director of Public Health. 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	**[DATE] 23rd March 2017** **[SIGNED BY CORONER]** Ian Wade