REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Department of Health, London
1	**CORONER** I am Ms L Hashmi, Area Coroner for the Coroner area of Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 24th May 2017 (case concluded on the 11th August 2017), I commenced an investigation into the death of **Christopher Ian Fairhurst.**
4	**CIRCUMSTANCES OF DEATH** The deceased was aged just 26 at the time of his death. Against a backdrop of an episode of impulsive self-harm in 2015, depression and a more recent diagnosis of adult Attention Deficit Hyperactivity Disorder (ADHD), the deceased was found on a footpath near Spotland Bridge, Rochdale on the 5th December 2016. Empty alcohol bottles and paracetamol packets were found in the immediate vicinity. He had last been seen by his family on the 3rd December 2016 and was subsequently reported to police as a missing person at 06:30 on the 5th December 2016. Initial enquiries were conducted however the deceased was found by members of the public at around 12:35 on the date of his death before any further steps could be taken by police to find him. Treatment for adult ADHD (namely, longer acting Methylphenidate) had been appropriately prescribed on or around the 8th November 2016. There was no causal connection made, on the evidence heard, between the medication prescribed and the deceased's actions. The evidence did not demonstrate, to the required legal standard, the necessary intent to reach a conclusion that the deceased took his own life. Conclusion: Misadventure
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:- Nationally: 1. There is a shortage of General Practitioners (GPs) as a result of recruitment and retention problems. Surgeries are working with only 50% (or less) of their required establishment. This puts patients at risk and places unmanageable workloads upon those GPs who are in post. 2. As a consequence of 1 above, many surgeries are heavily reliant upon locum GPs. For patients this brings about a lack of continuity of care, putting patient safety at risk. 3. In order to meet ever increasing demand and to reduce delays in accessibility, GPs are being forced to adopt alternative systems such as telephone consultations (upwards of 50 per day; this is over and above all other aspects of their job) rather than face to face appointments, offering patients appointments with other health care professionals rather than a doctor etc. Further, the average appointment with a doctor – where an appointment is secured – has decreased as a direct consequence of demand and is currently an average of 7.5 minutes per patient. This is insufficient in most cases and wholly inadequate in others e.g. where the patient has a complex medical history or mental health problems. Offering double or treble appointments does not solve this problem as it reduces the number of appointments available for others. 4. Patients frequently find themselves held in long telephone queues when trying to get appointments. When they eventually get through (often after half an hour or so of waiting), they are told that all appointments for that day have already gone. When they ring the following day, the situation is repeated. Patients often give up or spend days trying before they eventually get a GP appointment. At peak times (Monday/Friday mornings) surgeries can have as many as 300 incoming calls first thing. 5. GP training - GP trainees currently undertake a 3 year training programme. The overall view of the profession is that this is inadequate and ought to be no less than 5 years in order to ensure safe standards of care in general practice. By virtue of their role, GPs require high calibre, 'across the board' training in a significant number of specialities. The concept of a 5-year training programme is supported by the Royal College of GPs. Whilst I recognise that a longer training programme may result in a short term reduction in the number of doctors qualified/available for appointment, in the longer term doctors will be better qualified and more able to care for patients with increasingly complex health needs/problems. 6. Both adult and children's Autism and ADHD/ADD Psychiatric and Psychology services are currently struggling to cope with increasing demand for this area of mental health/neurodevelopmental care provision. The 'threshold' for referral and/or treatment has therefore been intentionally increased in order to try and address the problem. I am concerned that this is unsafe. It reduces patient accessibility to specialist diagnosis, care and treatment and places further burden upon GPs to care for patients with complex conditions.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 the 12th

	October 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 the following Interested Persons namely:- • The deceased's family • The Deceased's GP • Rochdale/Bury/Oldham CCGs • Royal College of GPs • Royal College of Psychiatrists • Pennine Care NHS Foundation Trust • Learning and Assessment Centre (LANC UK), Horsham ([redacted]) 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 from. 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: 16th August 2017 Signed: