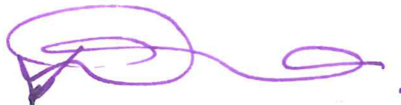
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Ms Claire Murdoch, Chief Executive Officer, Central and North West London NHS Foundation Trust, Trust Headquarters Executive Office, 350, Euston Road, London. NW1 3JN Simon Stevens, Chief Executive, NHS England, Skipton House, 80 London Road, London. SE1 6LH
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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.
3	**INVESTIGATION and INQUEST** On the 5th January 2019, evidence was heard touching the death of **Peter George Garvin.** Mr Garvin, had entered the Regent's Canal in Westminster on 31st January 2018, with the intention of taking his own life. He was 86 years old at the time of his death. The findings of the court were as follows: **Medical Cause of Death** 1 (a) Drowning **How, when and where the deceased came by her death:** Mr Garvin was suffering with a second episode of treatment resistant depression. He had previously attempted to take his own life in October 2017. At or around 10:35 on 31st January 2018 he entered the Regent's Canal in Westminster with the intention of taking his own life. There was no third party involvement. He was recovered and recognised as life extinct at 12:27. **Conclusion of the Coroner as to the death:** Mr Garvin took his own life whilst suffering with depressive illness.

4	**Circumstances of the death.** At the time of his death Mr Garvin was under the care of the Community Mental Health Team, however his medication was being prescribed by his GP. There were intermittent communication problems between the CMHT and the GP re his prescribing. In October 2017 he had required admission but due the lack of local beds he had been hospitalised in Milton Keynes. Mr Garvin's illness placed a lot of strain on his elderly wife, but she was not offered a carer's assessment prior to his death. His illness was treatment resistant, and he asked for private psychiatric assessment in a search of a cure. He saw a private psychiatrist on 19th January 2018. When the CMHT became aware that he had sought private treatment he was informed that he would be discharged from the CMHT. He was informed of this by his CPN at a home visit of 29th January 2018. This had a significant adverse effect on his mood. Just two days later, he took his own life. It is the policy of Mr Garvin's consultant to discharge patients from NHS care if they are taken for private treatment, apparently due to concern over potential communication difficulties. The private psychiatrist stated in evidence that she could only have seen Mr Garvin intermittently in out patients which in her view he was too ill for, or admit him to hospital. This would have deprived Mr Garvin of the option of being cared for at home in the community.
5	**Concerns of the Coroner:** 1. That there should be a system of doctor to doctor communication to facilitate prescribing, for example through direct email contact. 2. That there should be sufficient local beds so that such a vulnerable person should not have to be hospitalised so very far from home. 3. That if patients seek private psychiatric care they should not be discharged by the NHS. Instead a memorandum of understanding should be agreed between the NHS and Private psychiatric consultants to allow joint working and facilitate patient care. This should surely be possible along the lines of such agreements with GPs. 4. That carer's assessment should be undertaken early in the patient treatment pathway.
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. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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 :

	Consultant Psychiatrist, Community Mental Health Team, 190, Vauxhall Bridge Road, London. SW1V 1DX Nightingale Hospital, 11-19 Lisson Grove, Marylebone, London. NW1 6SH General Practitioner, St Johns Wood Medical Practice, Brampton House, Hospital of St John and St Elizabeth, 60, Grove End Road, London. NW8 9NH 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	**27th February 2019**  **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Honorary Professor QMUL School of Medicine and Dentistry**