Coroner ME Hassell
HM Senior Coroner
Inner North London

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: John Brouder Chief Executive North East London NHS Foundation Trust The West Wing CEME Centre Marsh Way Rainham RM13 8GQ
1	**CORONER** I am: Assistant Coroner Sarah Bourke Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE
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 21 September 2018, Senior Coroner Mary Hassell commenced an investigation into the death of Arun Viswambaran aged 27 years. The investigation concluded at the end of the inquest on 9 January 2019. The conclusion of the inquest was that Mr Viswambaran committed suicide. The medical cause of death was: 1a dihydrocodeine and paracetamol toxicity

	My short form conclusion was that "Mr Viswambaran took his own life at his home on 18 September 2018"
4	**CIRCUMSTANCES OF THE DEATH** Mr Viswambaran had recently started living with his partner in Tower Hamlets but remained registered with his family GP at the Redbridge Surgery, 49 Windermere Gardens, Ilford, IG4 5BZ. On 16 July 2017, he saw his GP and reported that he was depressed. His PHQ9 score of 19/27 suggested that he had moderately severe depression. He denied thoughts of suicide or self-harm. Following a discussion, he was prescribed Sertraline 50mg, given the crisis team contact number and details of how to refer himself to the IAPT service. He was reviewed on 3 August 2018 when he reported that he had not noticed much improvement in his mood and that he had tried to contact IAPT but had not had any response. It was decided that he would remain on Sertraline 50mg and would have a further review in 3 weeks' time. His family and friends noted that he was engaging less with other people, his mood was lower and that he was being increasingly critical of himself. Arun had a triage telephone call with the IAPT service and was placed on the waiting list. He did not attend any further GP appointments and would have run out of Sertraline in early September. On 18 September 2018, Mr Viswambaran told his partner that he was working a night shift and would be spending the day at home. He resigned from his job by email later that morning. In the early afternoon, he sent a number of text messages which concerned his friends. When they were unable to make contact with him, they asked police to break into the property. Mr Viswambaran was found dead in the bath. A subsequent post-mortem examination found that he had overdosed on co-dydramol tablets.
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 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) From the evidence of Mr Viswambaran's GP, [redacted], it transpired that the waiting time for IAPT therapy is in the region of 12 weeks but could be up to 18 weeks. I am concerned that individuals may experience a deterioration in their mental health pending an appointment or disengage from mental health services due to the length of waiting times for therapy. 2) Mr Viswambaran had problems making contact with the IAPT team by telephone in order to arrange the initial triage telephone call. I am concerned that this may discourage people from pursuing assistance from the service.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 22 March 2019. 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 [redacted] (father) I have also sent it to [redacted] and Senior Coroner Nadia Persaud (East London Coronial Area) who may find it useful or of interest. 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.
	Sarah Bourke **Assistant Coroner** **24 January 2019**