REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Practice Manager** **Old Catton Medical Practice** **55 Lodge Lane** **Norwich** **NR6 7HQ**
1	**CORONER** I am JACQUELINE LAKE, senior coroner, for the coroner area of NORFOLK.
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 19 May 2015 I commenced an investigation into the death of MARGARET CAROLE ANN PEGNALL, AGE 69 YEARS. The investigation concluded at the end of the inquest on 22 December 2015. The conclusion of the inquest was Medical Cause of Death: 1a) Multiple Injuries and the Conclusion: Suicide.
4	**CIRCUMSTANCES OF THE DEATH** On 18 May 2015 Mrs Pegnall stepped into the path of a train at Stracey Arms, Norwich. She turned her back on the train and raised her arms. She was hit by the train and died as a result of her injuries.
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:- (1) Mrs Pegnall went to see her GP on 19 January and 12 March 2015 regarding difficulties she was having with her husband. The GP asked questions with regard to depression using a Flowchart attached to the Surgery's Policy on Domestic Violence and Abuse. Mrs Pegnall wrote letters to the Practice referring to her interaction with the Police. Mrs Pegnall telephoned the Practice on the day of her death asking to speak to a particular GP who was absent requesting "intervention". (2) The Flowchart for Responding to Domestic Abuse is vague and uses an Assessment of Risk pertaining to depression and not to the risk of abuse (3) There is no Questionnaire specific to Domestic Abuse to assist in recognising signs of abuse and standardising the Surgery's GPs' response to concerns raised. (4) There was no method available to members of staff to recognise when a patient's call should be escalated and dealt with immediately.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 2 March 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: [redacted] (daughter). I have also sent it to [redacted] Independent Chair & Overview Report Writer 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.
9	**31 December 2015** ..... **Jacqueline Lake** **Senior Coroner for Norfolk**