REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Claire Murdoch** **Chief Executive** **Central and North West London NHS Foundation Trust** **Trust Headquarters** **Stephenson House** **75 Hampstead Road** **London** **NW1 2PL**
1	**CORONER** I am Dr Fiona Wilcox, 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 3oth October 2014 I commenced an investigation into the death of Mr Tommy Faegh Faisali aged 54 years. The investigation concluded at the end of the inquest on Tuesday 9th June 2015. The conclusion of the inquest was: Medical Cause of Death 1 (a) **Acute pulmonary oedema** **(b) Methodone toxicity** **(c) Liver failure due to cirrhosi** How, when and where the deceased came by his death: ***Mr Faisali suffered with hepatitis C which caused cirrhosis. He was also methodone dependent. On 30/9/2014 he was found deceased within his accommodation. There were no suspicious circumstances and no evidence that he intended to take his own life. The cirrhosis impaired his ability to metabolise the methodone.*** Conclusion of the Jury as to the death ***Drug related misadventure.***
4	**CIRCUMSTANCES OF THE DEATH** It was clear from the evidence taken during the inquest that despite four separate referrals by his GP to psychiatrists over the years, he had never been seen and assessed by one, such that he never received the benefit of specialist psychiatric input into the management of his complex psychiatric and psychological issues. He was only

	ever seen by CPNs or health care assistants or similar from the psychiatric services, none of whom where qualified to diagnose nor direct treatment. During the taking of the evidence it became clear that there was no evidence of any documented risk assessment, including suicide risk assessment being performed by the last mental health team providing care to him. His assessment by that team was also not recorded on his psychiatric notes in any contemporaneous way. All that could be found was a letter sent back to the GP after he was seen.
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) That patients referred by their GP for second opinion from psychiatrists are not being seen by the same but rather by psychiatric health care staff with less qualification to diagnose and assess and recommend treatment then the GP who made the referral. (2) That a shortage of appropriately qualified doctors is being compensated for by staff without the appropriate qualifications to provide the expert advice being requested by GPs when they make psychiatric referrals. (3) Those patients may be at increased risk because of (1) and (2) above. (4) That staff within the mental health teams are not completing risk assessments or at least not appropriately documenting that they are. (5) That risks to patients, including risk of suicide is thus not appropriately communicated to other team members, thereby increasing the risks to those patients. (6) That risks arising from (5) are even more increased given the team approach to care and lack of continuity of care inherent in such ways of working.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd September 2015. 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]

David Behan
Chief Executive
CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

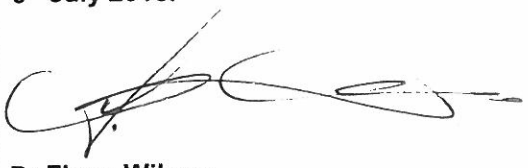
Rt Hon Jeremy Hunt MP
House of Commons
London
SW1A 0AA

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

6th July 2015.



Dr Fiona Wilcox,
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