REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. **Horsham and Mid Sussex Clinical Commissioning Group, Lower Ground Floor, Crawley Hospital, West Green Drive, Crawley RH11 7DH**
2. **Mike Pringle, President, Royal College of General Practitioners, 30 Euston Square, London NW1 2FB**

CORONER

I am Karen HENDERSON, Assistant Coroner for the Coroner area of West Sussex

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

INVESTIGATION and INQUEST

On 12th March 2014 I commenced an investigation into the death of Lee Hollman, 36 years of age. The investigation concluded at the end of the inquest on 12th March 2014. The medical cause of death given was:

1a. Quetiapine and Trazadone toxicity
1b.
1c
2.
My conclusion was: He took his own life.

CIRCUMSTANCES OF THE DEATH

Mr Hollman had a long history of intermittently severe mental ill-health. He was prescribed Quetiapine by his psychiatrists in May 2013 instead of Trazadone which was discontinued. He asked for a repeat prescription of his medication in November 2012 and Trazadone was prescribed as it was not removed from his repeat prescription. Mr Hollman's dose of Quetiapine was increased to 300mg in January 2014 following an overdose. Whilst this increased dose was added to his medical records, the previous lower dose (200mg) was not removed which resulted in two prescriptions being issued at his next repeat request. The system in place was that the duty doctor of the day, who may be a vocational trainee, was expected to sign all the repeat prescriptions (often over 100) of the day whilst having a clinic and organising visits and other issues which may arise. Also, there was no system to ensure that repeat prescriptions of more than one page were kept together. Mr Hollman did not have a review of his medication within GP practice guidelines. Whilst unused medication was kept at his house the circumstances were such that he was given a greater quantity of this medication that should have been prescribed. He took an overdose of Quetiapine and Trazadone and alcohol from which he succumbed on 28th February 2014.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise for 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. Failure to maintain sufficiently accurate and updated medical records
2. Failure to remove Trazodone from the repeat prescription record
3. Failure to delete the 'old' dosage of Quetiapine from the relevant medical records
4. The lack of an effective system to issue repeat prescriptions

5. Failure to review patients within their own guidelines with regard to repeat prescriptions

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation: Clinical Commissioning Group, Horsham and Royal College of General Practice have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th May 2014. I, the coroner, may extend this 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Properly Interested Persons - [redacted] (wife), [redacted] (parents) and [redacted] Mr Hollman's GP. I have also sent it to [redacted] and [redacted] 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.

DATE: 26th March 2014 **SIGNED: Karen Henderson, Assistant Coroner for West Sussex**