ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive NHS England Regus House 1 Emperor Way Exeter EX1 3QS** 2. **The Chief Executive Royal College of General Practitioners 30 Euston Square London NW1 2FB** 3. **The Chief Executive Devon Local Medical Committee Deer Park Business Centre Haldon Hill Kennford Exeter EX6 7XX** 4. **Fremington Medical Centre 11 – 13 Beards Road Fremington Barnstaple Devon EX31 2PG** 5. **The Chief Executive Devon Partnership NHS Trust Wonford House Dryden Road Exeter EX2 5AF**
1	**CORONER** I am John Geoffrey Tomalin, deputy coroner, for the coroner area of Exeter & Greater Devon.
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 2nd June 2016 I commenced an investigation into the death of Carly Marie GORDON (Mrs Gordon) date of birth 11th April 1980. The investigation concluded at the end of the Inquest on 19th July 2017. The conclusion of the inquest was that Mrs Gordon took her own life while suffering from a depressive disorder and the effects of withdrawal from Benzodiazepines.

4	**CIRCUMSTANCES OF THE DEATH** On the 20th May 2016 Mrs Gordon was admitted by ambulance to the A & E department of North Devon District Hospital, Barnstaple, North Devon, following a failed attempt on her own life. She was then admitted onto Ocean View psychiatric ward at the same hospital. Mrs Gordon was not under section but a voluntary patient and after initial assessments she agreed a treatment regime with the consultant psychiatrist and the mental health team. She was allowed to be collected by her parents during the day but return to the ward at night. On the 27th May 2016 after review with her consultant psychiatrist Mrs Gordon was collected by her mother and taken home. Later that same day she was found hanging in the garage of her home which was situated a few doors away from her parent's property. During the course of the Inquest it became apparent Mrs Gordon had a long history of anxiety and depression for which she received various medication including Lorazepam which had first been prescribed for her in August 2014. There had been attempts to reduce this drug from February 2016. Mrs Gordon found this difficult eventually attending a private clinic to manage the withdrawal shortly before the 20th May 2016. Although not taking this drug at the time of her death her consultant psychiatrist believes she was suffering from withdrawal state from Benzodiazepines which contributed to her anxiety and agitation as well as experiencing somatic symptoms. In the opinion of the consultant psychiatrist the long term use of Lorazepam was a contributory factor in Mrs Gordon's death.
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) The long term use of shorter acting Benzodiazepine instead of longer acting Benzodiazepine in accordance with the British Association of Psychopharmacology Guidelines should be followed when patients are prescribed this drug to avoid dependence. (2) All patients who receive this drug for an extended period of time should be reviewed by their medical advisors to reassess their suitability for the long term use of this particular medication.
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 29th September 2017. 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:

	     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	**4th August 2017** **John G Tomalin** **H.M. Deputy Coroner for** **Exeter and Greater Devon**