REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Heaton Moor Medical Practice, Chief Executive of Pennine Care, Chief Executive of Stockport Clinical Commissioning Group, Department of Health, Mayor of Greater Manchester.
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 25th July 2017 I commenced an investigation into the death of Peter STOJILJKOVIC. The investigation concluded on the 8th February 2018 and the conclusion was one of suicide. The medical cause of death was hanging.
4	CIRCUMSTANCES OF THE DEATH Peter Stojiljkovic was admitted to Norbury Ward and prescribed melatonin to try and address his sleeping problems. It was known that prescribing within the community was likely to encounter difficulties. He was discharged from hospital on 9th June 2017. The plan was for care by the Home Treatment Team until care was taken over by the Community Mental Health Team. This did not happen. On 12th June the GP refused to prescribe melatonin. On 20th June 2017 the psychiatrist indicated a 28-day prescription for melatonin would be given and other melatonin needed to be sourced independently. The GP practice had prescribed melatonin after reconsidering the position. This was not communicated to the deceased or the psychiatrist. On 22nd July 2017 Peter Stojiljkovic was found suspended by a ligature at his home address, [redacted]
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 deceased had been prescribed melatonin whilst an in-patient. The inquest heard that post his discharge communication between the hospital; GP and Mr Stojiljkovic was such that he was unaware that his GP was prepared to prescribe melatonin in the community; 2. Whilst an in-patient the deceased was prescribed a drug melatonin that was on the Stockport CCG blacklist although not on all GM CCG blacklists. It was unclear why Stockport CCG took a different approach too other CCGs 3. The inquest heard that GPs are faced with a mixture of lists regarding prescribing. National and local. This results in GPs having to negotiate through a complex system when prescribing where there are grey areas that create uncertainty. 4. The deceased was told he would have to source melatonin for himself over the internet if his GP would not prescribe it. This created a risk that he would have to access the drug from unlicensed sources. 5. It was known whilst he was an in-patient that difficulties with prescribing melatonin in the community would arise. There was no evidence of any attempt to communicate with the GP prior to discharge to ensure a smooth discharge into the community.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 9th May 2018. 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 namely [redacted] brother of the deceased, 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	**Alison Mutch OBE** **HM Senior Coroner** **14/03/2018**