	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Minister of State for Mental Health, Suicide Prevention and Patient Safety** **Nadine Dorries MP** House of Commons London SW1A 0AA **Email:** [redacted] **2. Chief Executive, MHRA** [redacted] 10 S Colonnade, Canary Wharf, London E14 4PU **Email:** [redacted]
1	**CORONER** I am Colin Phillips, acting senior coroner, for the coroner area of Swansea and Neath Port Talbot
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 29 January 2020 I commenced an investigation into the death of Samuel David Morgan aged 25. The investigation concluded at the end of the inquest on 1 December 2020. The conclusion of the inquest was Suicide with Narrative.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Samuel David Morgan ("Sam") and he died on the 16th January 2020 at his home Westway Heol Y Barna Pontlliw Swansea as a consequence of self-suspension. The risk of Sam taking his own life had not been identified. On the 9th January 2020 he had been prescribed a 14 day course of 10 mg citalopram anti-depressants. A review assessment was not set at the time of the medicine being prescribed in contravention of NICE Guidance.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – Sam's mother saw a change in his mood the 7 days before his death which she attributes to the effect of SSRIs. Whilst the precise effect of this medication (Citalopram) on Sam is unknown, it is clear that Sam had never self-harmed previously and his actions were completely out of character. He had started researching schizophrenia on his phone just before his death. Every medicine pack includes a patient information leaflet (PIL), which provides information on using the medicine safely and allows patients to read at their leisure. However, it has been suggested that the "Black Box Warning" (as developed by the Food and Drug Administration in the USA) would have a more

	immediate impact and capture some patient's attention highlighting any risks. The simple and clear message in this specific case would be that there is an increased risk of suicidal thinking in young adults. The benefits of such simple and direct messaging extends to all prescribed medicines and associated major risks.
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 3 February 2020. 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] (Parents) 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	**9.12.20**  **SIGNED BY CORONER**