REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • EMIS Health • The National Institute for Health and Care Excellence • Royal College of General Practitioners Copied for interest to: • Chief Coroner • [redacted] •
1	**CORONER** I am Mr Zak Golombeck, Area Coroner for Manchester (City) Area
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	**INQUEST** I concluded the inquest into the death of **Dyllon Shaun Graham Milburn** on 29th April 2021 and recorded that he died from: 1a Asphyxiation by ligature around neck
4	**CIRCUMSTANCES OF THE DEATH** The Deceased died on 8th October 2019 in the garden at his own home in Manchester from asphyxiation using a ligature made from a scarf. I returned a conclusion of Suicide following consideration of the evidence. One matter that was investigated was that the Deceased was prescribed the anti-depressant medication, Sertraline. His initial dose was 50mg, and this was then uptitrated to 100mg and 150mg. In July 2019 Sertraline was added to the Deceased's repeat prescriptions, despite evidence of non-compliance prior to this. The repeat prescription was for 28-day quantities of the 150mg dose. I was told by the Deceased's General Practitioner that there is nothing on the GP's EMIS system to confirm whether repeat prescriptions have been requested. The Deceased had periods of non-compliance with his Sertraline prescription, and therefore it would have been imperative for the surgery to ensure that he was requesting (and then collecting) his repeat prescription. This could not happen due to the limitations of the EMIS system.

	It was discussed with the GP at the Inquest whether the EMIS system could be updated to allow for (automated) alerts to be sent to patients to remind them about their repeat prescriptions, particularly for those patients who are prescribed anti-depressant medication (or any non-PRN medication).
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: The Deceased was suffering from a mental illness and had been non-compliant with this anti-depressant medication. The system for repeat prescriptions does not currently allow for alerts to be sent to a patient to remind them to request and collect their repeat prescription to encourage compliance. An automated alert to a patient could be added to the EMIS system, which would not increase the burden on the GPs and administrative staff at the surgery.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 **Monday 19th July 2021**. 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 Interested Persons. I have also sent it to organisations 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	**DATE:** 21 May 2021 **Signed:** 	**NAME OF CORONER:** **Mr Zak Golombeck** HM **Area** Coroner for Manchester City Area