REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) The Broadgate General Practice** **(2) The General Medical Council**
1	**CORONER** I am **HENRIETTA HILL QC**, Assistant Coroner, for the coroner area of Inner South District of Greater London.
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** **THE DECEASED**, who was born on [redacted], died on 22 November 2017 at St Thomas's Hospital, London. An investigation and an inquest into his death were opened. The inquest was conducted before me, sitting alone, from [redacted]. I summed up the evidence and gave my conclusions on [redacted]. The medical cause of the deceased's death was recorded as follows: I(a) hypoxic-ischaemic encephalopathy I(b) hanging. I returned a conclusion of suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased died on 22 November 2017 at St Thomas's Hospital, London as a result of the brain damage he sustained when he hanged himself at his home on 20 November 2017. Prior to his death, The deceased had been seen on several occasions by two GPs working at the Broadgate General Practice, Dr A and Dr B.
	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 that: 1. On 6 September 2017 the deceased telephoned his [redacted] GP who

prescribed him Zopiclone, Venlafaxine and Propanolol.

2. On 26 September 2017 the deceased saw Dr A. Dr A decided to change his medication and prescribed him Duloxetine and Zolpidem.

3. On 5 October 2017 the deceased saw Dr A again. The Zolpidem was swapped to Nitrazepam, a more potent sedative, as the deceased had said that after 2 weeks he had not found the Zolpidem to be effective. Expert evidence adduced at the inquest from [redacted] was to the effect that the deceased's presentation at this point should have triggered a further inquiry into his psychiatric history. [redacted] said that he would have contacted the deceased's home GP.

4. On 19 October 2017 the deceased saw Dr A again. He said he was feeling better on the Duloxetine but was still stressed and anxious and got a few anxiety attacks. Dr A prescribed him Propanol, Nitrazepam and Xanax. Dr A also prescribed the deceased 6 months' worth of Duloxetine. [redacted] evidence was that it was "*most unusual*" to prescribe such a large amount of medication (6 months' worth of Duloxetine) during the initial period where a patient's medication had been switched and where close monitoring was needed. He opined that the first 6 weeks of the 'switch' period were ones in which the patient might get ht et better, might get worse and might develop suicidal thoughts. [redacted] said that such a volume of medication was not merited clinica y an [redacted] and coul create a risk of overdose.

5. On 8 and 9 November 2017 the deceased saw Dr B. She made no notes of his presentation or diagnosis on any occasion when she saw him which she accepted she should have done. She also did not note her rationale for changing his medication which again [redacted] said should have happened. He also considered that Dr B should have examined the past records for the deceased which she accepted she had not done in full.

6. There are a series of further issues with the medication Dr B prescribed the deceased and her records of the same. The electronic patient notes reflect a prescription for Xanax but she said in evidence that the deceased had not in fact accepted this. She prescribed him Temazepam but this is a controlled drug in this country and cannot be prescribed in the usual way. She changed this to Nitrazepam but the dose was incorrect and this was refused by the pharmacy. The next day she prescribed him Lorazepam without him returning the Nitrazepam prescription to her. She made an error in the dose for Lorazepam and had to correct that. When he attended on 15 November 2017 asking for more medication she made no note of his attendance.

7. [redacted] evidence was that the multiple changes to the medication regime made by Dr B were not medically indicated and that the deceased clearly needed an urgent psychiatric referral. He said this was the case by 8 November 2017.

8. Overall [redacted] said his impression was that Dr B did not understand what she was prescribing.

9. I accepted [redacted] opinion on the various issues set out above.

	10. Large numbers of boxes of medication were found at the deceased's flat after his death by the police and his family. There remains some uncertainty as to where he obtained all the medication from, and what exactly he had taken and when.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe both organisations named above 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. The date would normally be 31 December 2018. Allowing for the holiday period I have extended this to **7 January 2019**. I, the Coroner, may extend the period further. 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] (the deceased's parents), **Dr A**, **Dr B** and the **South London and Maudsley NHS Trust**, who were recognised as Interested Persons in the inquest. A copy of this Report is also being provided to the **Care Quality Commission** ("the CQC"), pursuant to the Memorandum of Understanding between the Coroners Society and the CQC, paragraph 33. I am also 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	**Signed** .....***Henrietta Hill QC***..... **Assistant Coroner** **5 November 2018**