Regulation 28: AMENDED REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 **National Institute for Health and Clinical Excellence**
2 **The South London and Maudsley NHS Foundation Trust**
3 **Oxleas NHS Foundation Trust**
4 **Informa Healthcare**
5 **Tees, Esk and Wear Valleys NHS Foundation Trust**

1 CORONER

I am Oliver Robert Longstaff, HM Assistant Coroner for the area of County Durham and Darlington.

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 20th December 2018 I commenced an investigation into the death of Viktor John Anthony SCOTT-BROWN aged 23. The investigation concluded at the end of the inquest on 12th August 2020. The conclusion of the inquest was that the death was a suicide. The medically certified cause of death was:-

I a Hanging

4 CIRCUMSTANCES OF THE DEATH

Viktor John Anthony Scott-Brown was found hanging at his home address overnight on the 14th/15th December 2018 and pronounced dead at the scene. There were no suspicious circumstances. He had recently been prescribed Lamotrigine but had not been warned that use of that medication carries a risk of causing thoughts of self harm or suicide, and his taking of that medication was not monitored accordingly. Had he been informed of that risk, he would have sought medical assistance when he began to experience thoughts of self harm and suicide, and it is unlikely he would have taken his life when he did.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

Mr Scott-Brown was prescribed Lamotrigine by an NHS Foundation Trust Consultant Psychiatrist. The prescribing consultant did not give Mr Scott-Brown a Trust information sheet about Lamotrigine and a Patient Information Leaflet about Lamotrigine from the drug manufacturer, GlaxoSmithKline. It was common ground that the consultant should have done so. Both documents record as a side effect of using Lamotrigine a risk that the patient may begin to experience thoughts of self-harm or suicide. Mr Scott-Brown was never given that information.

The consultant gave evidence that he was not aware of that particular side effect of Lamotrigine, and that his prescribing practice was informed by the British National Formulary and The Maudsley

Prescribing Guidelines. Neither the online BNF viewable via the NICE website nor the 10th Edition of The Maudsley Guidelines (to which the court was referred) refer to that side effect in their respective entries for Lamotrigine.

Subsequent to the conclusion of the Inquest, I have learned from the Oxleas NHS Foundation Trust that when Mr Scott-Brown was prescribed Lamotrigine, the then current edition of the Maudsley Guidelines was the 13th Edition. The Inquest heard no evidence about the 13th Edition of the Maudsley Guidelines and information therein concerning Lamotrigine.

Quite apart from any issue regarding the consultant's knowledge about Lamotrigine (and the existence of the 13th Edition of the Maudsley Guidelines) and his not having given Mr Scott-Brown the Trust's prepared information about the drug and its side effects, I am concerned that two obviously reputable sources of pharmacological information are apparently silent, or have been silent, on a potentially significant side effect of this particular drug.

From a lay perspective, there is apparent potential for harm to patients depending upon which resources a prescriber consults before prescribing Lamotrigine. That potential for harm might be ameliorated were the advice about Lamotrigine consistent across all such resources.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

In the case of NICE, that power arises from the BNF being a resource accessible on the NICE website.

In the case of The South London and Maudsley NHS Foundation Trust and the Oxleas NHS Foundation Trust, that power arises from the credited authors and editors of The Maudsley Prescribing Guidelines (10th Edition) being in post within those Trusts respectively.

In the case of Informa Healthcare, that power arises from that corporate entity being the publisher of The Maudsley Prescribing Guidelines.

In the case of the Tees, Esk and Wear Valleys NHS Foundation Trust, that power arises from the Trust being in a position to ensure that its prescribers work with reference to the up to date edition of any resource upon which they rely for prescribing guidance.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 20th October 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

The next of kin of Viktor John Anthony Scott-Brown

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.

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