H.M. Coroner's Service for Cornwall & the Isles of Scilly
H.M. Coroner's Office, Pydar House, Pydar Street, Truro, Cornwall TR1 1XU

[redacted]

2 September 2023 [redacted]

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: The National Institute for Health and Care Excellence and the British National Formulary, Level 1A, City Tower, Piccadilly Plaza, Manchester, Mi 4BT** |
| 1 | **CORONER**<br><br>I am Stephen Covell, Assistant Coroner for Cornwall & the Isles of Scilly<br><br>Truro Coroner's Court, Pydar House, Pydar Street, Truro TR1 1XU |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 4 August 2022 I commenced an investigation into the death of Talia Evania Phillips. The investigation concluded at the end of the inquest on 9 March 2023.<br>The conclusion of the inquest was a narrative conclusion;<br><br>*"Talia Evania Phillips died at 19.55 on 6 March 2022 on the B3266 opposite the main entrance to the Colquite Estate near Washaway Bodmin as a result of catastrophic head and neck injuries sustained when the vehicle she was driving was in head on collision with an oncoming vehicle. The Deceased had been driving in the direction of Washaway when it crossed over the white line into the Camelford bound lane. It is likely that the Deceased lost control of her vehicle when she suffered a cardiac event caused by a significantly elevated level of the drug Fluoxetine in her blood which had been prescribed to her. There is insufficient evidence evidence to establish why the drug was at such a high level . There is no evidence that the Deceased had any intention to harm herself"*<br><br>The medical cause of death was 1a Head and neck injuries 1b Fluoxetine toxicity. |

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| 4 | **CIRCUMSTANCES OF THE DEAT**<br><br>**Talia Phillips died as a result of injuries sustained in a head on road traffic collision with an oncoming vehicle. It is likely that she lost control of her vehicle having suffered a cardiac event caused by a significantly elevated level of Fluoxetine in her blood.**<br><br>**Evidence from a toxicologist indicated that a chronically high level of fluoxetine may have led to arrhythmia in life and contributed to a collapse at the wheel.**<br><br>**Talia was prescribed Fluoxetine by her general practitioner on 22 December 2021 for anxiety. On 31 January 2022 Talia experienced an episode of palpitations and contacted her general practitioner who organised routine blood tests and an ECG. The tests and the ECG were reported as normal, save for slightly low iron levels. The routine tests did not test Fluoxetine levels.** |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows -<br><br>During the course of the inquest I heard that guidance around the prescribing of Fluoxetine did not indicate that fluoxetine levels would should be routinely tested in a patient prescribed Fluoxetine in the event of an episode of palpitations. Such a test may have identified chronically high levels of Fluoxetine.<br><br>It is requested that guidance in relation to the prescribing of Fluoxetine and management of patients on Fluoxetine should be reviewed to consider in what circumstances a blood test to establish the level of Fluoxetine in the patient's blood would be advisable. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, |

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| | namely by 30 October 2023. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the following;<br><br>Talia's Family<br><br>Wadebridge & Camel Estuary Practice<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | 4 September 2023<br><br>Signature  <br><br>Stephen Covell Assistant Coroner for Cornwall and the Isles of Scilly |