H G Mark Bricknell
Senior Coroner
for County of Herefordshire

4 October 2023

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Managing Partner, Hereford Medical Group
1	**CORONER** I am Hugh Gregory Mark Bricknell, Senior Coroner for County of Herefordshire
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 14 June 2023 I commenced an investigation into the death of Ronald Leslie HARRIS. The investigation concluded at the end of the Inquest on 27 September 2023. The conclusion of the Inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** a) On the 24th April 2023 the Patients' wife contacted the practice indicating her husband had mental health difficulties. The symptoms were said to be getting worse. b) The Patients' family requested further help from the surgery on the 27th April 2023. The family were very concerned, indicating behaviour out of character and requesting GP input. Were told to expect a call the following week. c) A routine appointment was offered which the Inquest was advised would be 4-6 weeks. No call was made. d) The Patient received correspondence (copy to GP) in connection with cancerous lesions dated 23rd May 2023. No apparent reference on documents supplied to Inquest showing mental health position and no connection made between mental health position and correspondence. e) The Patient committed suicide on the 5th June 2023
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. – (1) Triage documentation was not fully completed. (2) The patient was not telephoned as requested and as advised they would be. (3) The Inquest was advised the triage Doctor was not aware of the waiting time for a routine appointment (4-6 weeks) nor did he consider the transcript of the telephone call. (4) The Deceased died on the 5th June 2023. The Inquest was told that a significant event meeting on the 9th August 2023 had indicated a review of protocol criteria for triaging patients with mental health problems was being undertaken. The Inquest was held on the 27th September 2023 no revised protocol was advised.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, [redacted] 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 29 November 2023. 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 Local Mental Health 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	4 October 2023 Signature HG Mark Bricknell, HM Senior Coroner