Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO: Stretton Medical Centre**
1	**CORONER** I am Victoria DAVIES, Area Coroner for the coroner area of Cheshire
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 23 September 2021 I commenced an investigation into the death of Olivia Amy RUSSELL aged 25. The investigation concluded at the end of the inquest on 6 December 2023. The conclusion of the inquest was one of suicide.
4	**CIRCUMSTANCES OF THE DEATH** Olivia Russell had a history of anxiety which was initial managed without medication. In October 2020 she contacted your surgery and discussed options to treat her anxiety as this had worsened. She initially decided against anti-depressants but subsequently had another appointment on 2 November where she opted for a 10mg dose of citalopram. Following a period of apparent stability, Olivia stopped taking her medication in or around June 2021 without consulting a GP, subsequently suffering a relapse and re-starting her medication in August 2021. Sadly, Olivia took her own life on 19 September 2021.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) During the inquest, evidence was heard from [redacted], one of your salaried GPs as to his interactions with Olivia, and based on the records, his colleagues' interactions. There was no evidence within the notes that the risk of relapse if a medication is stopped was discussed in either November 2020 or August 2021, nor is there evidence that Olivia was told she may feel worse before she feels better. I did not find that this advice was not given, simply that I could not say either way. When asked, [redacted] evidence was that you would discuss the risks when prescribing the drug, but was not entirely clear as to which risks he would discuss, and gave evidence that it is likely each GP has a different approach, bearing in mind the time limitations of the appointment. He could not say with confidence that every GP within the practice was discussing these key risks.

	A copy of the relevant NICE guidance was provided to me which states that these risks should be discussed with the patient, and I look specifically at sections 1.3.1 and 1.5.2 as a minimum. I am concerned that this guidance is not being followed as a matter of routine within the surgery and that this gives rise to a risk of future deaths. I am also concerned that a significant event meeting (acknowledging I may have the name of this review meeting incorrect) has not yet taken place, despite Olivia's death being over 2 years ago. The evidence of [redacted] was that this will take place after the inquest and I am concerned that, if this is the practice following all deaths, there is a risk that learning from deaths will be delayed or missed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 January 31, 2024. 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 family of Olivia Marks and Spencer [redacted] I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 14/12/2023** V Davies **Victoria DAVIES** **Area Coroner for** **Cheshire**