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:** **1 Chelsfield Surgery**
1	**CORONER** I am Laura BRADFORD, Assistant Coroner for the coroner area of East Sussex
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 04 July 2023 I commenced an investigation into the death of Thomas Joseph GERAGHTY aged 39. The investigation concluded at the end of the inquest on 21 June 2024. The conclusion of the inquest was: Suicide
4	**CIRCUMSTANCES OF THE DEATH** On the morning of 28 June 2023 Thomas Joseph Geraghty entered the sea from the beach at Eastbourne. He was not witnessed entering the water. At around 11:45, Mr Geraghty's body was seen floating by a nearby lifeguard and he was recovered to the beach. Resuscitation was attempted however it was sadly unsuccessful and death was confirmed.
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) Mr Geraghty had been prescribed anti-psychotic medication since 2007, which he took on a daily basis. His symptoms responded well to the medication and his mental health was assessed in 2015 as stable. Mr Geraghty informed his family that he felt safe taking his medication and had intended to remain on it for life. In January 2021, Mr Geraghty's GP surgery noted that he had moved out of its catchment area and a letter was sent to him advising him to register with a new surgery closer to his new home address. Mr Geraghty does not appear to have registered with a new surgery and remained a patient of his original surgery. He continued to receive a repeat prescription for his anti-psychotic medication and received his COVID vaccinations and also text messages from the surgery relating to smoking cessation advice up to November 2021. On 4 May 2022, the surgery sent Mr Geraghty a text message to confirm that they were still prescribing his medication and that he needed to provide his new surgery details. No details were provided by Mr Geraghty and he continued to be prescribed his anti-psychotic medication with the last prescription, a two-month supply, issued on 10 November 2022.

	Mr Geraghty requested a repeat prescription via his usual automated service on 12 January 2023. Mr Geraghty appears to have been deregistered as a patient by the surgery on 16 January 2023 and there does not appear to have been any communication with Mr Geraghty at this time to inform him of the deregistration. Two chaser emails were sent to the surgery by the pharmacy to seek authorisation for the prescription but no response was received and Mr Geraghty, who had not yet registered with another surgery went without his anti-psychotic medication. He was not on any medication at the time of his death and family noted that some of his psychotic symptoms had returned in June 2023. I have a concern that individuals can be removed from the surgery as patients without any scrutiny as to whether the individual may be receiving vital medication (either for a mental health or physical health issue). There does not appear to be any process of review in relation to these patients to ensure that they will continue to receive their medication after they are deregistred from the surgery. This is of particular concern where a patient is deregistered and the surgery has not been provided with details of an individual's new GP. There is a concern that in these circumstances, an individual may be left without access to medication, which could cause or contribute to their death.
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 August 16, 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 **Mr GERAGHTY's family** 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: 21/06/2024** L Bradford **Laura BRADFORD**

	Assistant Coroner for **East Sussex**