	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Dearne Valley Group Practice**
1	**CORONER** I am Marilyn Whittle, Assistant Coroner, for the Coroner Area of South Yorkshire West
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 28 March 2024 I commenced an investigation into the death of David Stables. The investigation concluded at the end of the inquest on 4 December 2024. The conclusion of the inquest was Suicide 1a Bilateral transection of the ulnar arteries 1b Incised wounds to the wrists
4	**CIRCUMSTANCES OF THE DEATH** David Stables had a history of mental health issues and had taken two drug overdoses in 2020. He was prescribed sertraline in April 2020 and weaned himself off this in 2023. His last prescription was issued in July 2023. David attended many appointments at his GP practice from 2020 to 2023 regarding other issues unrelated to his mental health. In most of these encounters there is no record of any discussions regarding his mental health. Whilst he received repeat prescriptions for his sertraline, there is no recorded entry of a review of his mental health or appropriateness of the medication. It is noted that he had reduced this himself yet there is no recorded entry of a full review of his mental health at this time. I am concerned that there were no recorded mental health or medication reviews from April 2020 until February 2024 when David attended the GP asking for help. I was unable to establish whether these reviews had taken place and just not been recorded or whether full mental health reviews had not taken place when they should have been. In February 2024 he attended the GP surgery and had a face to face appointment regarding his mental health. He had anxiety and had difficulties in sleeping and poor appetite. A shared decision was undertaken to put David

	on mirtazapine at 15mg and to follow up in 4 weeks time. I was informed that this was considered because of its side effects of sedation and increased appetite. A full mental state examination was undertaken which did not identify any Self harm or suicidal concerns. On 18 March 2024 he was seen again by the GP and there was some improvement. I was told that self harm and suicidal ideation were specifically discussed and they were strongly denied at both appointments. There was no concern from the GP when he called 2 days later to ask to increase his medication although it was accepted that had she known he had tried to contact the GP surgery on 5th 14 and 15th March then this may have changed her management in terms of obtaining more information either by reception or by another appointment. However, I do find that whilst he may have attempted to contact the GP it cannot be ascertained if these calls actually made it through to the reception team. I find that there is no evidence to say that this would have changed the management in terms of the medication although it may have been considered. Further there is evidence that even if medication had been increased it could have taken up to 4 - 6 weeks to show any benefit. David had been given all relevant safety netting advice for a crisis and this was provided verbally and by text message.
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) I am concerned that there were no recorded mental health or medication reviews from April 2020 until February 2024 when David attended the GP asking for help. I was unable to establish whether these reviews had taken place and just not been recorded or whether full mental health reviews had not taken place when they should have been. (2) (3)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Dearne Valley Practice 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 31 January 2025. 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: Family - [redacted] 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	6 December 2024 Signature  Marilyn Whittle H.M Assistant Coroner for South Yorkshire West