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:** **The Royal College of General Practitioners (RCGP), 30 Euston Square, London, NW1 2FB**
1	**CORONER** I am Sarah Murphy, Assistant 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 09 September 2024 I commenced an investigation into the death of Joseph David POWELL aged 28. The investigation concluded at the end of the inquest on 13 May 2025. The conclusion of the inquest was: Suicide against a background of post-traumatic stress disorder and depression. The medical cause of death was: 1A Hanging 2 Post traumatic stress disorder and depression.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was 28 years of age with a medical history of mental illness. In March 2024 he was diagnosed with depression and was prescribed Sertraline for 28 days. He did not receive a further prescription for this as he had not booked a follow up appointment with his GP as requested. On the 22 August 2024, he re-presented to his GP surgery and was diagnosed with post traumatic stress disorder and an exacerbation of his depression. He denied any active suicidal thoughts but had experienced suicidal ideation. He was prescribed Citalopram, and provided with a telephone number for a local psychotherapy service and agreed to make a follow up appointment for a review with the GP in one to two weeks' time. He did not subsequently book a review appointment with his GP. On the 6th September 2024, he was found at his home address suspended [redacted]. He was cut down and cardiopulmonary resuscitation was commenced whilst waiting for paramedics to arrive. He did not respond to resuscitation and death was certified on the scene by paramedics at 21:24 hours.
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: 1) That not all GPs book follow up appointments for patients presenting with mental health difficulties such as depression, anxiety and post-traumatic stress disorder.

	Instead, they request that the patient book their own follow up appointment with their GP. This can be difficult for patients who are suffering with mental health difficulties and can result in patients not receiving a follow up appointment with their GP or any further medication.
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 July 14, 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 I have also sent it to Family of Joseph Powell Counsel for the GP surgery. who may find it useful or of interest. 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 17 May 2025 Ms Sarah Murphy HM Assistant Coroner for Cheshire.