



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	<p>REGULATION 28 REPORT TO PREVENT DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1 NHS England</p>
1	<p>CORONER</p> <p>I am Laura BRADFORD, Senior Coroner for the coroner area of East Sussex Coroners Service</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 10 October 2024 I commenced an investigation into the death of Louis Robert SAUNDERS aged 23. The investigation concluded at the end of the inquest on 25 February 2026. The conclusion of the inquest was that:</p> <p>Louis Robert Saunders was diagnosed with Attention Deficit Hyperactivity Disorder ("ADHD") in October 2022. Louis was under the care of a private ADHD clinic and was started on medication and once stabilised, his care was transferred to his NHS GP. Louis experienced negative side effects from his medication, including suicidal ideation and in June 2024 he mentioned that he had thoughts of travelling to cliffs in East Sussex. It is understood following this, Louis stopped taking his medication and there was no medication found in his system following his death. On 31 July 2024, Louis contacted his health insurer to be referred for further therapy (having previously found it beneficial) and he was awaiting assessment. In the months following, Louis continued to receive privately funded therapy and during this time his behaviour was noted to be changeable. On 8 October, Louis made a further call to his insurer to query about therapy and a follow-up appointment was arranged. On 9 October 2024, Louis travelled from his home address in London to the East Sussex coast, arriving at 09:30. Later that evening his car was found parked in a layby. The following morning, a backpack was found on the cliff edge which contained Louis' belongings and a search was undertaken. Louis' body was found at the base of the cliff below the area where the backpack was found and his death was confirmed at the scene (on 10 October 2024 at 10:21).</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Louis was diagnosed with Attention Deficit Hyperactivity Disorder ("ADHD") in October 2022. He was diagnosed by a private ADHD clinic and was started on medication by that clinic. Once stabilised, his care was transferred to his NHS GP under a shared care agreement. Louis experienced negative side effects from his medication, including suicidal ideation and in June 2024 he mentioned that he had thoughts of travelling to cliffs in East Sussex. It is understood following this, Louis stopped taking his medication and there was no medication found in his system following his death. Between July 2024 and October 2024, Louis had contact with both his NHS GP and multiple private therapy providers, he received Eye Movement Desensitization and Reprocessing ("EMDR") treatment and contacted his health insurer to seek talking therapy during this time. On 9 October 2024, Louis travelled from his home address in London to the East Sussex coast, arriving at 09:30. Later that evening his car was found parked in a layby. The following morning, a</p>



	<p>backpack was found on the cliff edge which contained Louis' belongings and a search was undertaken. Louis' body was found at the base of the cliff below the area where the backpack was found and his death was confirmed at the scene.</p>
5	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)</p> <p>Whilst it is understood that Louis had stopped taking his medication due to a perceived increase in suicidal ideation, and no medication was found in his system following his death, the evidence identified that he was being prescribed ADHD medication by both his NHS GP and the private ADHD clinic. Neither organisation was aware of the other's ongoing prescribing until the time of the inquest.</p> <p>After Louis' ADHD treatment was transferred to his GP, the plan was for the surgery to continue issuing his medication. Accordingly, on 6 November 2023, the surgery issued a prescription for Lisdexamfetamine ([REDACTED]). However, Louis had attended an appointment at the ADHD clinic the previous day, on 5 November 2023, and the clinic's notes record that he was to continue on Dexamfetamine ([REDACTED]). Although the medications have similar names, they are distinct drugs with different dosing requirements. Effective management and titration are understood to be essential to ensure therapeutic benefit and limit adverse effects.</p> <p>The concern that has arisen relates to continuity of care between private providers and the NHS once a patient has been diagnosed with ADHD, commenced on medication, and subsequently transferred to GP care. In Louis' case, communication between the private sector and the NHS was insufficiently clear, and the situation became more complex when he continued to be seen by both the ADHD clinic and his GP. This created opportunities for key information to be missed.</p> <p>Although medication was not directly implicated in Louis' death, there remains a risk that a patient may inadvertently obtain duplicate prescriptions or become confused about which medication to take. Such scenarios may pose a risk of future deaths. As increasing numbers of patients are receiving ADHD diagnoses and commencing treatment in the private sector due to long NHS waiting times, I am concerned about the robustness of current processes to ensure safe and continuous care following transfer to a GP.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by April 24, 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to Louis' family and the following Interested Persons:</p> <ul style="list-style-type: none">• [REDACTED]



- Nuffield Health Wellbeing Service

I have also sent it to the following who may find it useful or of interest:

- [REDACTED]- ADHD Taskforce
- Royal College of Psychiatrists •
Royal Pharmaceutical Society

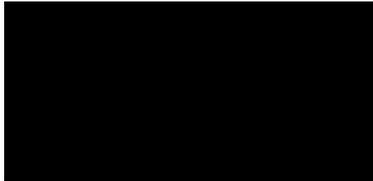
I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

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: 27/02/2026



**Laura BRADFORD
Senior Coroner for
East Sussex Coroners Service**

