	REPORT TO PREVENT FUTURE DEATHS **REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013**
1.	**CORONER** I am Alison LONGHORN, Area Coroner, for the County of Devon, Plymouth & Torbay.
2.	**DATE OF REPORT** 25th June 2026
3.	**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.	**THIS REPORT IS BEING SENT TO** 1. The Foxhayes Surgery GP Practice You are under a duty to respond to this report within 56 days of the date of this report, namely by the 20th August 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**ACTION SHOULD BE TAKEN** In my opinion, unless action is taken to address the concerns below, then there is a significant risk of future deaths, and I believe you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** A coronial investigation was commenced on 1st September 2023 into the death of David Paul Joyce, aged 33, who had been found deceased on 31st August 2023 at his home address of 52 King Arthur's Road, Exeter, having ligatured [redacted]. The investigation concluded at the end of the inquest on 17th June 2026. The medical cause of death was recorded as 1a) asphyxia due to hanging and the conclusion was suicide.
8.	**CIRCUMSTANCES OF DEATH** David Joyce had a history of mental health difficulties. In 2018 a psychiatric review diagnosed that David was having an acute dissociative episode and he was prescribed Quetiapine. In the summer of 2023, having had a period of some stability, his mental health deteriorated following the breakdown of a relationship, and he was experiencing feelings of low mood and having difficulty sleeping. He initially consulted the GP about this on 16th May and was encouraged to go back to work and get out of the house.

	In June 2023, David was arrested having taken an overdose of paracetamol and caused damage to his room; he was seen by the Criminal Justice Liaison & Diversion Team in custody and was referred for support and advised to contact his GP. He approached his GP and disclosed that he had not been taking his Quetiapine since he'd moved to Exeter some years previously, and that he considered his most pressing symptom now was depression rather than anger. The GP issued a prescription for Quetiapine, seemingly with no consideration of a referral to mental health services, or any request for specialist psychiatric input regarding appropriate medication. On 22nd August, David was found in a local wood [redacted]. He was encouraged down and detained under the Mental Health Act. A mental health act assessment was conducted; David was referred to the Home Treatment Team and was seen by them on a number of occasions during which rapport was built and a plan for care going forward considered. David consulted with his GP again on 24th August and requested an urgent medication review. The GP advised that it would not be appropriate for her to make changes to his medication given that he was under the support of the Home Treatment Team, and, in evidence, said she thought the medication review would be undertaken by them. No medical review was conducted until 31st August, at which point alternative medication was prescribed, which was considered more appropriate to David's symptoms. Later that evening, David was found dead at his home address of 52 King Arthur's Road, Exeter, having suspended himself [redacted] He had written a note to his family which was found [redacted].
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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. David first presented to the GP surgery on 16th May 2023, reporting a deterioration in his mental health. No follow up was initiated by the surgery despite David's recorded past medical history of dissociated disorder, self-harm and suicide. There was no evidence that, on that occasion, there had been any consideration of referral to secondary or tertiary mental health services which may have been available to assist David and inform his care; 2. David presented to the GP surgery again on 26th June. He reported that he'd had a 'severe mental breakdown due to ongoing psychosis' which had resulted in him taking an overdose and being arrested for being in possession of a weapon, and he'd been advised by Police mental health services to contact his GP for support. When he spoke to the GP, David informed her that he considered his most significant issue currently was depression, and said that he had not taken Quetiapine since he moved to Exeter some years previously. Despite the fact that David indicated depression to be his overriding concern, he had taken an overdose which resulted in hospital attendance, and he'd not taken Quetiapine for some time (and seemingly for different symptoms), the GP prescribed Quetiapine, without seeking guidance or input from a psychiatrist or mental health professional about whether that was an appropriate medication in the circumstances. No routine follow up appears to have taken place following that consultation. The next communication does not occur until the GP is informed that there had been a further suicide attempt resulting in a Mental Health Act Assessment of David on 22nd August. 3. On 31st August 2023, when a medication review was conducted, it was established that David needed a different medication given his presenting symptoms. This medication amendment therefore did not take place until 15 weeks after David had initially sought help from the GP.
10.	**COPIES AND PUBLICATION OF THIS REPORT**

	I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. The family of David Joyce 2. Devon Partnership NHS Trust I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.	
	SIGNATURE [redacted]	Alison Longhorn, Area Coroner