REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health**
1	**CORONER** I am Jonathan Mark Layton senior coroner, for the coroner area of Carmarthenshire and Pembrokeshire.
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 6th March 2012 I commenced an investigation into the death of Lee Jay Bonsall then aged 23. The investigation concluded at the end of the inquest on 31st January 2014. The conclusion of the inquest was a narrative verdict namely that the deceased had suspended himself by a ligature from a bannister railing at his home address on 3rd March 2012 but the question of intent remains unclear. The medical cause of death was asphyxia by hanging.
4	**CIRCUMSTANCES OF THE DEATH** (1) Mr Bonsall had joined the Army at the age of 17 and had served in Afghanistan. During his tour of Afghanistan he witnessed the death of a close friend. (2) An army psychiatrist subsequently deemed Mr Bonsall temperamentally unsuitable for service. He was discharged from the Army in September 2007. (3) Mr Bonsall continued to suffer from depression. He relocated to West Wales and registered with a surgery in 2010. After an assessment he was prescribed citalopram. He later renewed his prescription which his GP put on repeat prescription. This is contrary to good practice guidelines. (4) His GP considered counselling as an alternative to citalopram but did not refer Mr Bonsall for psychotherapy as there was a ten month waiting list. (5) Mr Bonsall was found hanging from a bannister rail at his home address by his wife on 3rd March 2012.
5	**<u>CORONER'S CONCERNS</u>** 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) That citalopram was given on repeat prescription which is contrary to guidelines. It may well be that awareness of these guidelines needs to be raised to ensure that GPs are aware that citalopram should not be given on

	(2) The ten month waiting times for psychotherapy effectively means that this is not a viable alternative to anti-depressant medication and it might well be that a review of these waiting times is appropriate.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 the 28th March 2014. 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: [redacted] DAC Beachcroft LLP Portwall Place Portwall Lane Bristol BS99 7UD Defence Inquest Unit Directorate of Judicial Engagement Policy 2nd Floor Zone 5 IDL 432 Ramilies Building Marlborough Lines Monxton Road Andover Hants SP11 8HJ 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	**31st January 2014** **Signed:**