ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Ms S. Horsfall** **Chief Executive** **National Patient Safety Agency** **4-8 Maple Street** **London W1T 5HD**
1	**CORONER** I am David Clark Horsley, senior coroner, for the coroner area of Portsmouth and South East Hampshire.
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 22nd November 2012 I commenced an investigation into the death of George Douglas Stone, aged 37. The investigation concluded at the end of the inquest on 16th August 2013. The conclusion of the inquest was that the medical cause of George Stone's death was Yew Tree Leaf Intoxication and he had taken his own life whilst suffering from a long term depressive disorder.
4	**CIRCUMSTANCES OF THE DEATH** George Stone suffered from long term depressive illness. In August 2012 he was prescribed Venlafaxine which caused him to suffer a grand mal seizure on 6th September 2012. This in turn led to an exacerbation of his depressive illness and he ended his own life on 19th November 2012.
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. – I was told in evidence at the Inquest that a side effect of Venlafaxine and similar antidepressants is seizures and that although this is rare, these seizures can be very severe - as was the case with George Stone. I was also told that the NPSA issues national guidelines for the warnings practitioners must give their patients who are prescribed these sorts of antidepressants but the risk of patients suffering a severe seizure is not included in the guidelines at the present time.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by consideration of changes to the guidelines for prescribing Venlafaxine and similar antidepressants to include a specific warning to patients about the risks of their suffering severe seizures whilst taking these medications. I believe your organisation has 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 15th October 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: Mr Stone's parents, [redacted] I have also sent it to the Coroners Society of England and Wales who may find it useful or of interest. 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	**20th August 2014** **David Clark Horsley**