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:** 1. [REDACTED] **General Practitioner, The Knoll Surgery Partnership, Princeway Health Centre, 2 Princeway, Frodsham, Cheshire, WA6 6RX**
	CORONER I am Alan Wilson, Senior Coroner, for the area of Blackpool & Fylde
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 21st June 2013 an investigation commenced into the death of **Stephen James Morris**, aged **44 years**. The investigation concluded at the end of the inquest on 15th October 2013. The record of the inquest confirmed as follows: The Medical cause of death was 1a Aspiration pneumonitis 1b Inhalation of Gastric Contents 1c Combined toxic effects of Lithium and Mirtazapine The conclusion of the Coroner as to the death was Stephen Morris took his own life
4	**CIRCUMSTANCES OF THE DEATH** As regards the circumstances by which the Deceased came by his death, the inquest concluded that Stephen James Morris had previously been diagnosed as suffering from bi-polar affective disorder a number of years ago. Having spoken on the telephone to his family during the evening of Sunday 16th June 2013 he was found deceased at approximately 1015 hours the following morning lying in the bath at the flat where he resided. A subsequent post mortem examination confirmed the presence of high levels of mood stabilising and anti – depressant medication the combined effects of which proved fatal.
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. –

At the conclusion of the inquest, I indicated to the Properly Interested Persons that I proposed to write to the Trust by way of a report in accordance with the provisions of paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009.

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During the Inquiry, I received evidence from you that during a consultation at your surgery with the Deceased on 7th March 2013 Mirtazapine medication was prescribed for Stephen James Morris, a Patient of your surgery and one you knew had previously been referred to the Community Mental Health Team at the Cheshire & Wirral Partnership NHS Trust.

Such medication was prescribed despite the fact that you were aware that such medication may not have been the preferred medication for someone previously diagnosed as suffering from Bi-polar affective disorder, and upon verbal information provided to you by the Patient himself who informed you that this was in accordance with the care and treatment being provided by the Community Mental Health Team.

Having concluded this inquest, I now write to you to confirm that in my view you should take action because:

- I am concerned that medication was prescribed to a Patient you knew had previously been referred to the local hospital Trust in respect of his mental health and the diagnosis that had been made.
- That you prescribed the medication on the basis of verbal information provided by the Patient rather than seeking some confirmation form those within the Hospital Trust with responsibility for the Patient’s mental health care provision.
- That knowing the diagnosis, you prescribed medication you acknowledged was not the preferred medication for this Patient’s condition and seemingly in the absence of discussion with those who had responsibility for the Patient’s mental health care.

I would therefore be obliged if the Trust would write to me in due course to confirm what steps if any you propose to take to address these concerns.

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 23rd January 2015. 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 The family of Stephen James Morris The Chief Coroner of England & Wales The Lancashire Care NHS Foundation Trust The Cheshire and Wirral NHS Foundation Trust 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	A.A.Wilson **Alan Wilson** **Senior Coroner for the area of Blackpool & Fylde** **Dated: 29th August 2014**