CLAIRE BALYSZ
Assistant Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **New Court Surgery, Borough Fields, Royal Wootton Bassett, Swindon SN4 7AX.**
1	**CORONER** I am CLAIRE BALYSZ, Assistant Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 18/11/2014 an investigation into the death of Tania Salekovna Hristova, 50 . The investigation was concluded by myself at the end of the inquest on 06 May 2015. The conclusion of the inquest was Suicide Tania had suffered from depression since 2009, she was treated with Citalopram and continued to receive this via repeat prescription. Her young son had been diagnosed with attention deficit hyperactivity disorder and Tania found his behaviour distressing. There is no record over the course of her treatment that she received or was offered counselling, nor that her medication and mental health was reviewed adequately. On the morning of her death, Tania spoke to her daughter who was in Bulgaria at the time. Tania was distressed and upset but took her son to school. By the time she met the school administrative assistant, Tania seemed normal again. However she failed to collect her son from school and was later found hanging by a ligature at her home address. Suicide notes were left and there were no suspicious circumstances.
4	**CIRCUMSTANCES OF THE DEATH** Tania had registered with her GP in 2001. In January 2005 she was started on Mirtazapine for Depression. However her social situation improved and she stopped taking them in February 2005. In February 2009 she presented with low mood and was started on Citalopram. Tania remained on 40mg Citalopram from March 2010 until her death. However the evidence I heard at Inquest showed that not only had there been a failure to offer this patient counselling or CBT, there was also a failure to review her adequately. Tania had been prescribed Citalopram for 5 ½ years by requesting repeat prescriptions and occasional appointments.
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. – (1) This patient was prescribed antidepressant medication for 5 ½ years without adequate review.

	(2) This patient was not offered additional therapy such as counselling or CBT to help her deal with her illness.
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 23 November 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 following Interested Persons [redacted] I have also sent it to the Secretary of State for Health, The Rt Hon Jeremy Hunt MP 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	Dated 28 September 2015 Signature Claire Bailey. Assistant Coroner for Wiltshire and Swindon