REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **The Director of Primary Care:** [redacted] Woodley Centre Surgery, 1st Floor, 6 Headley Road, Woodley, Reading, RG5 4JA.
1.	**CORONER** I am Peter James Bedford, Senior Coroner, for the coroner area of Berkshire.
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** I conducted an Inquest into the death of Mr George Arthur Cheese that was heard at Reading Town Hall between the 23rd and 25th May 2017 inclusive. The conclusion of the Inquest was that Mr Cheese took his own life whilst suffering from a depressive disorder brought on by a series of life events. A full copy of the Narrative Conclusion is attached.
4.	**CIRCUMSTANCES OF THE DEATH** Mr Cheese was an 18 year old young man who was found hanging in Woodland near his home address on 9th April 2015. He had a number of ongoing issues in his life including the potential loss of a career in the army; a fluctuating relationship with his girlfriend; an unsubstantiated concern that he might have a serious illness and he had been subject to upsetting treatment by his colleagues at work. He was under the care of his GP surgery and the local Mental Health Team who were treating him for anxiety and depression including prescribing anti-depressant medication.

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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 could occur unless this action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

(1) While the evidence at the Inquest dealt with the various matters ongoing in Mr Cheese's life, I also heard evidence of the care and treatment that he received from his GP surgery. One of the doctors at the surgery, [redacted] gave live evidence at the Inquest.

(2) Mr Cheese was prescribed Fluoxetine anti-depressant medication on the 3rd November 2014 by a treating GP, following admitting to fleeting suicidal thoughts. He was reviewed by [redacted] on 14th January 2015 when Mr Cheese described daily episodes of intense low mood with suicidal thoughts which included taking an overdose. This led to a reference to the Mental Health Team. At an appointment with the Practice's Nurse Practitioner on 3rd February, Mr Cheese was prescribed 112 tablets of Fluoxetine. In the course of her evidence, [redacted] stated that the Nurse Practitioner was probably just repeating the same prescription that the previous Doctor had issued to Mr Cheese but that she, [redacted], would not have done that.

(3) [redacted] also acknowledged, in the course of her evidence, that there was no "flag" on Mr Cheese's notes to alert treating Clinicians within the GP Practise to limit the amount of medication provided to Mr Cheese in view of his history. She acknowledged that a flag, in such circumstances, was good practise.

(4) The concerns arising from the evidence are therefore the amount of medication prescribed to a patient who was known to be suffering from mental health issues and describing suicidal thoughts and a potential overdose and the fact that this was not being flagged to prevent large amounts of medication being provided to him as a matter of repeat prescription.

6. **ACTION SHOULD BE TAKEN**

In my opinion urgent action should be taken to prevent future deaths in such circumstances and I believe your Surgery has the power to take such action.

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7.	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **2nd August 2017**. 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 family of Mr Cheese. You are 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.	**6th June 2017** **Peter J. Bedford** **Senior Coroner for Berkshire**