VERONICA HAMILTON-DEELEY DL, LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
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CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO: **1. Chief Executive, Sussex Partnership NHS Foundation Trust** **2. [redacted] Medico-Legal Manager, Sussex Partnership NHS Foundation Trust** **3. [redacted], Consultant Psychiatrist** **4. [redacted] Care Co-ordinator, Sussex Partnership NHS Foundation Trust**
1	**CORONER** I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
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 27th June 2018 I commenced an investigation into the death of John Michael KIRBY. The investigation concluded at the end of the inquest on 28th November 2018.The conclusion of the inquest was HE TOOK HIS OWN LIFE.
4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest
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.

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	The **MATTERS OF CONCERN** are as follows: – (1) The delay in dealing with Mr Kirby between August 2017 and March 2018. (2) I am concerned about the decision to ask him to complete ADHD questionnaires and apparently suggest that he should be prescribed Concerta. (3) I am concerned that although [redacted] told me he had made a diagnosis of ADHD in October 2017 he did not follow the NICE Guidance, inform the GP, start prescribing, consider alternatives to prescribing, have a formal note made of the consultation with John when the impact of this diagnosis was discussed with him or discuss the diagnosis with his immediate next of kin. (4) On the last occasion when John was seen, ie. on March the 20th diagnosis of ADHD was discussed and [redacted] decided not to prescribe Concerta. A few weeks later, in April, he received a letter from Mr Kirby's GP explaining that John wanted to be prescribed Concerta and also saying that he had had an admission to A&E. This did not provoke any further review of Mr Kirby, he was simply prescribed the medication without any discussion as to his previous drug abuse or current dependence on Diazepam, suicidal tendencies or binge drinking. This is outwith the Guidance issued by NICE. (5) Why was Mr Kirby prescribed Concerta without any (further) review? (6) Why was he not properly monitored as he should have been had the NICE Guidance been adhered too? (7) Even if Concerta had not been prescribed the GP letter and the information in the electronic records as to the A&E admission on the 4th-5th April should have alerted the Trust to the information John had given that he was suicidal and "wanted to die". (8) Why did those interviewing John in A&E not take more details of the suicide attempt when he said that recently he had tried to hang himself and only failed because the rope broke?
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND 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 27th February 2019. 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.

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8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons 1. [redacted] - Spouse 2. [redacted] – Sister 3. [redacted] – Sister 4. [redacted] - Daughter 5. [redacted] – Daughter 6. Care Quality Commission 7. Clinical Commissioning Group 8. Patient Safety Agency 9. Secretary of State for Health, Department of Health 10. Simon Stevens, Chief Executive, NHS England 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.
	Date: **6th December 2018** **SIGNED BY:** V. Hamilton Deeley **Senior Coroner Brighton and Hove**