RESPONSE TO REGULATION 28 CORONER'S REPORT TO PREVENT FUTURE DEATHS

1	**THIS RESPONSE IS MADE ON BEHALF OF** The General Medical Council
2	**REGULATION 28 REPORT** This response follows a report by Assistant coroner Henrietta Hill QC dated 6 November 2018
3	**INVESTIGATION AND INQUEST** The inquest in question relates to the death of the deceased, who died on 22 November 2017 at St Thomas's Hospital, London. An inquest into his death concluded on [redacted]. The medical cause of the deceased's death was recorded as follows: (a) hypoxic-ischaemic encephalopathy (b) hanging. A conclusion of suicide was returned.
4	**CIRCUMSTANCES OF THE DEATH** The deceased died on 22 November 2017 at St Thomas's Hospital, London as a result of the brain damage he sustained when he hanged himself at his home on 20 November 2017. Prior to his death, the deceased had beenn several occasions by two GPs seen o working at the Broadgate General [redacted] and Dr B (Dr [redacted], Dr
5	**CORONER'S CONCERNS** The matters of concern set out by the Coroner are that: 1. On 6 September 2017 the deceased telephoned his [redacted] GP who prescribed him Zopiclone, Venlafaxine and Propanolol. 2. On 26 September 2017 the deceased saw Dr A. Dr A decided to change his medication and prescribed him Duloxetine and Zolpidem. 3. On 5 October 2017 the deceased saw Dr A again. The Zolpidem was swapped to Nitrazepam, a more potent sedative, as the deceased had said that after 2 weeks he had not found the Zolpidem to be effective. Expert evidence adduced at the inquest [redacted] was to the effect that the deceased's presentation at this point should have triggered a further inquiry into his psychiatric history. Dr [redacted] said that he would have contacted the deceased's home GP. 4. On 19 October 2017 the deceased saw Dr A again. He said he was feeling better on the Duloxetine but was still stressed and anxious and got a few anxiety attacks. Dr A rescribed him Pro anol Nitraze am and Xanax. Dr A also

prescribed the deceased 6 months' worth of Duloxetine. Dr [redacted] evidence was that it was "most unusual to prescribe such a large amount of medication (6 months worth of Duloxetine) during the initial period where a patient's medication had been switched and where close monitoring was needed. He opined that the first 6 weeks of the 'switch' period were ones in which the patient might get better, might get worse and might develop suicidal thoughts. Dr [redacted] said that such a volume of medication was not merited clinically and could create a risk of overdose.

5. On 8 and 9 November 2017 the deceased saw Dr B. She made no notes of his presentation or diagnosis on any occasion when she saw him which she accepted she should have done. She also did not note her rationale for changing his medication which again Dr [redacted] said should have happened. He also considered that Dr B should have examined the past records for the deceased which she accepted she had not done in full.
6. There are a series of further issues with the medication Dr B prescribed the deceased and her records of the same. The electronic patient notes reflect a prescription for Xanax but she said in evidence that the deceased had not in fact accepted this. She prescribed him Temazepam but this is a controlled drug in this country and cannot be prescribed in the usual way. She changed this to Nitrazepam but the dose was incorrect and this was refused by the pharmacy. The next day she prescribed him Lorazepam without him returning the Nitrazepam prescription to her. She made an error in the dose for Lorazepam and had to correct that. When he attended on 15 November 2017 asking for more medication she made no note of his attendance.
7. Dr [redacted] evidence was that the multiple changes to the medication regime made by Dr B were not medically indicated and that the deceased clearly needed an urgent psychiatric referral. He said this was the case by 8 November.
8. Overall Dr [redacted] said his impression was that Dr B did not understand what she was prescribing.
9. The coroner accepted Dr [redacted] opinion on the various issues set out above.
10. Large numbers of boxes of medication were found at the deceased'ss flat after his death by the police and his family. There remains some uncertainty as to where he obtained all the medication from, and what exactly he had taken and when.

6 **ACTION TAKEN/TIMESCALE**

1. As a result of a referral from the Metropolitan Police Service dated 4 May 2019 in relation to Dr [redacted] and the care provided to the deceased, an investigation was opened by the GMC. An Expert Report was requested and this has now been received.

   Under Rule 7 of the Fitness to Practise Rules 2004 [redacted] will now be written to formally to:
   (a) inform them of the allegation and state the matters which appear to raise a question as to whether their fitness to practise is impaired;
   (b) provide them with copies of any documents received by the General Council in support of the allegation;
   (c) invite them to respond to the allegation with written representations within the period of 28 days from the date of the letter; and
   (d) inform them that representations received from them will be disclosed, where appropriate, to the maker of the allegation (if any) for comment.

   At the end of the investigation, and following the 28 day period allowing for

	comments from [redacted] the case will be referred to two senior GMC staff known as case examiners, one medical and one non-medical, who will review all the evidence collected and make a decision on the outcome of the investigation (Rule 8). The outcome of an investigation can be to: • conclude the case with no further action • the doctor being given advice • the doctor being issued a warning • the doctor agreeing to undertakings to address a problem, or • refer the case to the Medical Practitioners Tribunal Service (MPTS) for a hearing. Medical practitioners tribunals consist of specially trained people, both lay and medical, who will hear all the evidence and decide at the end of the hearing whether the doctor's fitness to practise is impaired and, if so, what sanction may be needed to protect the public. If the tribunal finds that the doctor's fitness to practise is impaired they can do one of the following: • place conditions on the doctor's registration so that they are only allowed to do medical work under supervision or so that they are restricted to certain areas of practice • suspend the doctor's name from the medical register so that they cannot practise during the suspension period • remove the doctor's name from the medical register so that they cannot work as a doctor in the UK for at least five years, and possibly for life. In the event of a referral to MPTS, the estimated timeframe for the hearing to commence is 9 months after the decision to refer has been made. 2. Following the conclusion of the Inquest on [redacted] an investigation has been opened in relation to Dr [redacted] It is the intention of the GMC to request an Expert Report to comment on the care the deceased received from Dr [redacted] Expert Reports can take around two months to produce. Upon receipt of the Expert Report a decision will then be made as to how the case should progress. It is likely that the investigation will progress to Rule 7 and follow the same process as detailed above but this will be assessed upon receipt of the Expert Report.
7	**THIS RESPONSE HAS BEEN PREPARED BY** [redacted], Head of Regional Investigation Team, General Medical Council
8	**DATE OF RESPONSE** 7 January 2019