IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Matthew John Evans
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • **Chief executive, NHS England** • **Mr Sajid Javid, Health Secretary, Department of Health** • **CQC** • **GMC** • **CCG – Surrey (North East)** • **Dr** [redacted] • **Farnham Park GP practice**
1	CORONER Dr Karen Henderson, HM Assistant Coroner for Surrey
2	CORONER'S LEGAL POWERS I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	INVESTIGATION and INQUEST On 20th April 2022 I commenced and concluded an investigation into the death of Matthew John Evans. The medical cause of death given was: 1a. Suspension I determined that on the 16th June 2021 Matthew John Evans was found deceased at [redacted], Folly Hill, having [redacted] with the intention of ending his life.

1.	CIRCUMSTANCES OF THE DEATH Matthew was a 47-year-old man who worked in IT and was fit and well with no underlying medical or mental health difficulties. On or around December 2020, despite coping well with the 2 previous Covid-19 lockdowns he began catastrophising and developed insomnia through the third lockdown. This worsened and he sought help from his General Practitioner in April 2021. Matthew sent an email regarding his insomnia to his GP who thereafter had a telephone consultation on April 14th 2021, referring Matthew for Cognitive Behaviour Therapy (CBT) for insomnia. Matthew had CBT with TalkPlus between April and July 2022. His initial depression and anxiety (PHQ-9 and GAD-7) scores were in the severe range and had deteriorated further when recalculated at the end of the sessions. In May 2021, he indicated a suicide risk of 5/10 and 4/10 on the final session. His suicide risk was discussed with other practitioners but referral to further mental health care was not considered warranted. After his last session Matthew was recommended to have a more intensive course of CBT which had not commenced at the time of his death. TalkPlus sent a letter to the GP outlining the care to be offered to Matthew and thereafter a follow up letter indicating the care they had provided. Both these letters indicated Matthew was suffering from insomnia, anxiety and depression with the severe PHQ-9 and GAD-7 scores. Matthew had further telephone consultations, with his GP on 27th May, 2nd and 9th June 2021 all of which were initiated by him via email. His request for sleeping medication was initially refused but after a further request he was prescribed Zopiclone. On 9th June 2021 he was prescribed Mirtazapine for ongoing anxiety, depression and insomnia. On the 16th June 2021 he ended his life.

5	CORONER'S CONCERNS 1. The actions of the General Practitioner The GP was not sufficiently proactive with multiple lost opportunities to provide better care and support for Matthew. The GP did not undertake a mental health assessment to assess the severity of Matthew's difficulties and to ascertain whether further support or referral to secondary mental health care were indicated in any of the four telephone consultations. He did not ask or document at any time if Matthew had any suicidal ideation or acts of self-harm. The GP did not offer a face-to-face consultation or arrange a follow up appointment. The GP declined to prescribe Zopiclone and whilst he referred Matthew to the benefits of Melatonin he did not offer a prescription. He prescribed Mirtazepine having not done so before for someone in Matthew's position on a background of having no post graduate qualifications in mental health. Furthermore, he did not document any warning of the possible side-effects of this drug including the possible increased risk of suicidal ideation with commencing the drug. It is unclear whether the GP had read the letters from TalkPlus. He did not ask permission as to whether it was possible to inform or involve Matthew's partner and family in his on-going care. 2. The actions of the General Practice No policy was provided to assist GP's with prescribing of Mirtazapine and antidepressants and anxiolytics in general practice. There is no confirmation electronic letters have been signed as read and acted upon by the relevant GP. No evidence was provided with regard to ongoing training in mental health for GP's. Matthew's death was not investigated or reviewed by the GP practice with the consequence no learning points have been considered or, if necessary, changes implemented, giving rise to concern over the lack of robust clinical governance procedure within the practice. 3. The actions of TalkPlus There does not appear to be robust guidance or a policy as to the threshold necessary to refer a patient to secondary mental health services in Matthew's circumstances where his mental health had deteriorated as the sessions proceeded and he had began to indicate suicidal ideation and self-harm on a background of no previous mental health difficulties.

6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one have the power to take such action.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise, you must explain why no action is proposed.
8	COPIES I have sent a copy of this report to the following: 1. See names in paragraph 1 above [redacted] In addition to this report, I am 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.
	Signed: Karen Henderson DATED this 18th Day of May 2022