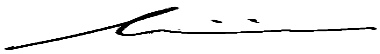
M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

28th April 2022 [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Royal College of General Practitioners** **British Medical Association** **The Minister of State for Patient Safety, Suicide Prevention and Mental Health**
1	**CORONER** I am M E Voisin Senior Coroner for **Area of Avon**
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 02/02/2022 I commenced an investigation into the death of Susan Elizabeth Carling. The investigation concluded at the end of the inquest 27th April 2022. The conclusion of the inquest was that of suicide.
4	**CIRCUMSTANCES OF THE DEATH** Susan was a General Practitioner she died on 2nd January 2022 at her home address. She was found [redacted].
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. – Her family brought to my attention that there are approximately 100 people in the health service who commit suicide each year. They requested that in my role to prevent future deaths that this is considered by someone who could potentially take action to prevent future deaths in this profession going forward. I am aware and made it clear to the family that there are organisations that GP's can access for support

	however they like I agree that this needs to be highlighted if suicides are to be prevented in this vulnerable professional group.
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 13th July 2022. 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 following interested persons – the family of the deceased. 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	28/04/2022 Signature  **M E Voisin Senior Coroner Area of Avon**