REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dr Andrew White, Director of Clinical Services, Greater Manchester Medicines Management Group** **2. Dr Simon Woodworth, Medical Director, NHS Stockport Clinical Commissioning Group**
1	**CORONER** I am Jason Wells, Assistant Coroner for the Coroner Area of Greater Manchester South.
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 5th November 2018 an investigation was commenced into the death of SAM ROBSON PRINGLE (dob 26th April 1990). The investigation concluded at the end of the inquest on 6th December 2019. **The conclusion of the inquest was suicide, the medical cause of death being** **1 a) Hanging**
4	**CIRCUMSTANCES OF THE DEATH** (1) Sam Pringle (SP) had a long history of mental health problems. (2) In September 2018 SP was informally admitted to Norbury Ward with a diagnosis of ADHD, alcohol dependence and bipolar affective disorder. Prior to discharge the prescription of Lithium was discussed; SP was to visit his GP once he had decided if he wished to take this drug. He was discharged on sertraline. (3) On 2nd October 2018 SP approached his GP, having chosen to start Lithium; the GP (correctly) did not instigate Lithium, as per the shared care protocol. (4) At inquest, the consultant psychiatrist stated that some GPs follow the protocol and some don't, and that it was common to ask GPs to instigate Lithium treatment despite the protocol. (5) SP was seen in psychiatric outpatients later in October 2018 and alternative medication was prescribed. (6) SP committed suicide by hanging on 3rd November 2018.
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 action is taken. In the circumstances it is my statutory duty to report to you.

	The **MATTERS OF CONCERN** are as follows – (1) The inquest heard evidence that some psychiatrists are asking GPs to instigate prescriptions of Lithium, knowing that the shared care protocol (should) prevent GPs from doing so; as a result the provision of Lithium to mentally ill patients is either not happening or is being delayed, with potentially fatal results.
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 17th June 2020. 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: [redacted] (father). I have also sent it to the Care Quality Commission, who may find it useful or of interest. 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	 **Jason Wells** **HM Assistant Coroner** **22.04.2020**