REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Medical Director,** **Windsor and Maidenhead Community Mental Team,** **Reform Road,** **Maidenhead,** **SE16 8BY** **Medical Director,** **Wokingham Community Mental Health Team,** **The Old Forge,** **45-47 Peach Street,** **Wokingham,** **Berkshire,** **RG40 1XJ** **Medical Director,** **Hafod Community Mental Health Team,** **Beechwood Road,** **Rhyl,** **Denbighshire,** **LL18 3EU** **Director of Mental Health,** **NHS England** **PO Box 16738** **Redditch** **B97 9PT**
1	**CORONER** I am Dr Fiona Wilcox, Senior Coroner, for the coroner area of Inner West London
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 Wednesday 5th September 2012 I commenced an investigation into the death Mr Keiran Michael John Toman aged 39 years. The investigation concluded at the end of the inquest on Wednesday 16th April 2014. The conclusion of the inquest was: Medical Cause of Death 1 (a) **Emaciation**

	How, when and where and in what circumstances the deceased came by his death: ***Mr Toman suffered with drug induced fixed delusional disorder from 1998. This was treatment resistant, and led him to becoming socially isolated and self-neglecting and ultimately to his death. He was discovered deceased in his room at Hyde Park Tower Hotel on 23/7/2010.*** Conclusion of the Coroner as to the death ***Natural Causes***
4	**CIRCUMSTANCES OF THE DEATH** It was clear from the evidence taken during the inquest that Mr Toman suffered with fixed delusions into which he had no insight. He resigned form his job and cut all social contacts. As part of his illness he then cut off contact with his family following his first psychiatric admission under Section 3 of the Mental Health Act in 2007 to Heatherwood Hospital, due to this lack of insight. Despite his lack of capacity to make such decisions, the psychiatric services subsequently involved in his care at Heatherwood Hospital, Wokingham CMHT and the Hafod Community Mental Health Team, North Wales, made no contact with his family, even when as part of his illness Mr Toman removed himself from psychiatric care and follow up. Mr Toman was thus left completely without support and deteriorated until the point where he starved himself to death due to his paranoia and was found deceased in Hyde Park Towers Hotel by cleaning staff. It was the clear view of the senior psychiatrist from whom evidence was taken in this inquest, that information should be shared with all those involved in the care of such patients including their families/next of kin.
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. – (1) That some psychiatric staff and services may effectively collude with patients by acquiescing to requests not to pass on information to their families, when these decisions are taken by patients who have insufficient insight to make them. (2) That the lack of contact with families in such circumstances may leave vulnerable patients isolated and increase their risk of deterioration and death, as occurred in this case and in others that I have investigated. (3) That some psychiatric staff may be insufficiently trained to assess the capacity of patients to decline contact with next of kin and thus the best interest of such patients is compromised. (4) That where decisions are taken by psychiatric staff not to contact family in line with a patients wishes in order to try and keep that patient engaged with services, that contact is still not made to the family or next of kin even when such a patient disengages from the psychiatric services.

	(5) That permission to contact next of kin/ family decisions taken by patients may not be reviewed often enough by those providing psychiatric care, such that information in relation to changes in treatment, mental state, discharge, provider of care etc may not be being appropriately communicated to the detriment of patients.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. ***It is for each of the parties to whom this Prevent Future Death Report is addressed to identify the matters of concern that they should respond to.***
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 7th July 2014. 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 : Consultant Psychiatrist, Private Psychiatry LLP, Orchard House, High Street, Leigh, Kent. TN11 8RH. CPN and Care Manager, Wokingham Community Mental Health Team, The Old Forge, 45-47 Peach Street, Wokingham, Berkshire. RG40 1XJ Consultant Psychiatrist Hafod Community Mental Health Team

	Beechwood Road RHYL Denbighshire LL18 3EU **Care Quality Commission,** **Legal Services,** **Citygate,** **Gallowgate,** **Newcastle-upon-Tyne.** **NE1 4PA** 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	**12th May 2014** **Dr Fiona Wilcox,** **HM Senior Coroner,** **Inner West London,** **Westminster Coroner's Court,** **65, Horseferry Road,** **London.** **SW1P 2ED.**