REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and Central)]
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 the 10th of February 2014 I commenced an investigation into the death of Christopher Paul Davies (DOB 13.02.79, DOD 05.02.2014). The investigation concluded at the end of the inquest on the 26th of September 2014 and I recorded a conclusion of Accidental Death with the cause of death being 1(a) Clozapine Poisoning
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are that Christopher Paul Davies was found unresponsive at his home address on the 5th of February 2014 and was verified dead at 16.39 on the same date.
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 :- The father of the Deceased [redacted] indicated that his son would drink significant amounts of caffeinated drinks and had also cut down on his smoking and that he felt this may have had a bearing on the levels of clozapine in his system and also that the flu like symptoms which his son had prior to his death may have been the result of clozapine toxicity. He stated that although his son's clozapine levels were being regularly monitored, at no point was he ever made aware of the possible interaction between caffeine or the cessation/reduction of smoking in relation to clozapine levels, nor was he made aware of the possible warning signs of toxicity.

	It was therefore felt that there should be greater emphasis placed on the sharing of this knowledge with users and with staff within the Community Mental Health Team. It was also felt that due to memory issues, patients should be regularly reminded of this information.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 24th November 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 Person – [redacted] (Father 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	**[DATE] 29th September 2014 [SIGNED BY CORONER]**