Her Majesty's Coroner for the Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
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Barnet EN5 4BE

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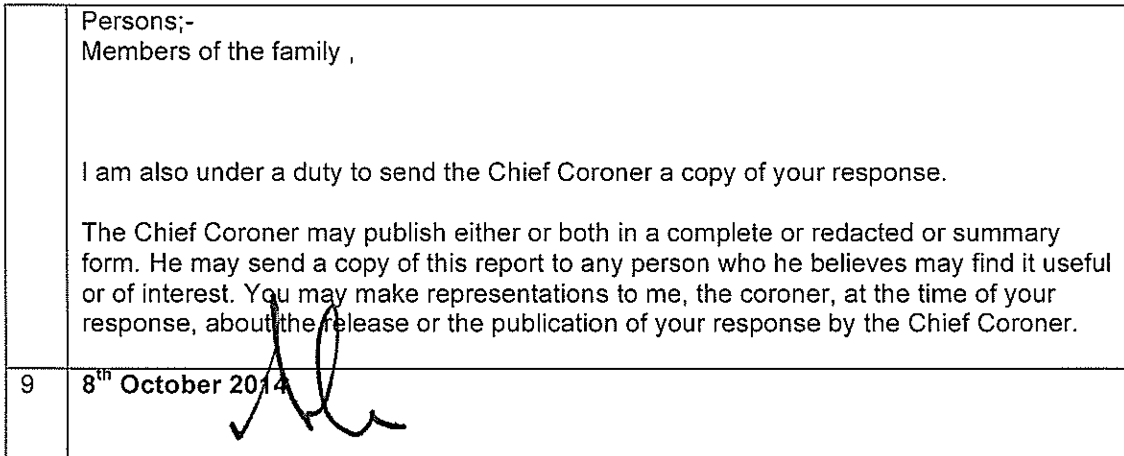
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
2	**CORONER'S LEGAL POWERS** I make this report 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 the 25th June 2012 I opened an inquest touching the death of Chloe Siokos, 80 years old. The inquest concluded on the 29th July 2014. The conclusion of the inquest was "Unlawful Killing", the medical case of death was 1a Incised wound to the throat and blunt force trauma to the head.
4	**CIRCUMSTANCES OF THE DEATH** On the twenty second of January 2013 Chloe Siokos was found in a kitchen at her home having been killed by her husband who had set a fire in the house before hanging himself. There were 3 relevant factors :- That Mrs Siokos shared a home with Mr Siokos. That Mrs Siokos was subject to a pattern of abuse by Mr Siokos over a number of years. That Mr Siokos had, at some point, begun to suffer a deterioration in mental health leading to a delusional state of mind. Mr Siokos had no history of psychiatric illness and he never showed any psychotic ideation. On the 16th January 2013 the GP telephoned to speak to Mr Siokos but spoke to Mrs Siokos instead. Mrs Siokos asked the doctor if it was about the results of the X-ray that was undertaken on the 11th January 2013. The doctor explained that it was. Mrs Siokos then called for Mr Siokos to come down from upstairs, the portion of the house where he lived separate from Mrs Siokos, The doctor explained that there was a problem

	with the X-ray and that Mr Siokos would need to be seen urgently the following day. Mr Siokos then asked the doctor to speak to Mrs Siokos again and it was agreed that Mrs Siokos would bring him in to see a different doctor . Concerns were raised at the inquest about whether in the circumstances, that Mr and Mrs Siokos lived separately at the same address, had separate door bells and Council Tax and largely lived separate lives an interpreter should have been used. Concerns were also raised that when looking at Mr Siokos's GP notes there was no flag to indicate that it may not be appropriate to use Mrs Siokos as an interpreter for Mr Siokos. Mrs Siokos did accompany Mr Siokos to that appointment and again assisted with interpreting what was said.
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. – That there was no framework for primary care staff to make a decision when an interpreter is required. That interpreters should be available to primary care staff more readily That there is no system of flagging to alert primary care staff to the need to consider the care provided to a patient in the context of another patient where that is relevant.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 2nd December 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;- Members of the family , 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	**8th October 2014**