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 4th day of April 2014 I opened an investigation touching the death of John Ioannou , 58 years old. The inquest concluded on the 21st November 2014. The conclusion of the inquest was "Suicide", the medical case of death was 1a Multiple Injuries.
4	**CIRCUMSTANCES OF THE DEATH** On the 4th April 2014 shortly before 9.56 hrs John Ioannou jumped from a window at his home fatally injuring himself. Mr Ioannou had not been taking medication from mid-September the year before and had begun to become seriously unwell. Mr Ioannou was being treated for Bipolar Affective Disorder under the care of Barnet, Enfield and Harringey Mental Health Trust and also the urology department at the Whittington Hospital. Mr Ioannou was also being treated for hypertension by his GP who prescribed the medication to treat his Bipolar Affective Disorder. Mr Ioannou was last prescribed 1 months supply of medication for his Bipolar Affective Disorder on the 16th August 2013. It would have been of assistance to the Mental Heath Team to know that Mr Ioannou had not been taking his medication as he had not been to his GP to collect further prescriptions since August 2013.

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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. – There was no guidance for GPs where the patient is not collecting medication required to treat their mental health condition (s).
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 Monday 30th February 2015. 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;- Representatives of the family and the Mental Health Trust. 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	**6 January 2015**