REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO** Rt Hon Matt Hancock MP Secretary of State for Health Department of Health and Social Care 39 Victoria Street London SW1H 0EU
1	**CORONER** I am Shirley Radcliffe, Assistant 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** **On 5th February 2016 I opened an inquest into the death of Daniel Young, then aged 30 years.** **The inquest concluded on 28th and 29th June 2018. The conclusion of the inquest was a narrative conclusion, the medical cause of death was shock and haemorrhage due to stab wound to the abdomen.**
4	**CIRCUMSTANCES OF THE DEATH** 1. Daniel Young was a fit and healthy university lecturer. On 19th January 2016, he was randomly attacked on his way to work. He sustained a fatal stab wound to the abdomen. 2. His attacker (ML) had been a patient of local mental health services. He had suffered from periods of psychosis. He was known to be aggressive when psychotic. 3. At the time of the attack, ML was living in the community with no secondary mental health follow up. He had been discharged to his GP and told to remain on his antipsychotic medication for at least 6 months and only reduce them slowly, if at all. He was told that stopping the medication may lead to a relapse of his psychosis. 4. ML stopped his antipsychotics soon after discharge from the CMHT. 5. At the criminal trial ML was found guilty of manslaughter by reason of diminished responsibility.
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.

	The **MATTERS OF CONCERN** are as follows. – 1. When ML was discharged to the care of his GP by the Community Mental Health team, he was warned not to stop his medication because of the risk of relapse. 2. GP surgeries do not routinely monitor that psychiatric patients are collecting their antipsychotics. Evidence revealed that it is not uncommon for such patients stop their medication and relapse. Relapse puts them at a risk of harm to themselves and, sometimes, they pose a risk to others. 3. Following the death of Mr Young, the GP responsible for the care of ML has implemented a system within the practice to monitor the collection of antipsychotic medication of their patients. This is funded by the practice. 4. I attach a copy of the Protocol for Monitoring Collection of Antipsychotic Prescriptions.
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 24th September 2018. 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] - Parents of Daniel Young (address known to the court) 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	**26th July 2018**  **Dr Shirley Radcliffe,** **HM Assistant Coroner for Inner West London,** **Westminster Coroner's Court,** **65, Horseferry Road,** **London.** **SW1P 2ED**