HM Assistant Coroner
for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** (1) National Institute for Health and Care Excellence 10 Spring Gardens London SW1A 2BU (2) Avon and Wiltshire Mental Health Partnership NHS Trust Bath NHS House Newbridge Hill Bath BA1 3QE
	CORONER I am Nicholas Rheinberg, Assistant Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 31st January 2019 an investigation was commenced into the death of Thomas Wedrychowski and thereafter an inquest was opened on 1st February 2019. On 28th November 2019 I concluded the inquest. I found that the medical cause of death was **1a) diabetic ketoacidosis** **1b medication induced diabetes mellitus (Type 1)** My conclusion was that the deceased died by misadventure
4	**CIRCUMSTANCES OF THE DEATH** The deceased had been diagnosed as suffering from paranoid schizophrenia. For a number of years he was prescribed anti-psychotic medication. Expert evidence at the inquest was to the effect that the medication had caused the deceased to develop diabetes and that such causation was both a direct consequence of taking anti-psychotic medication and also indirect in that the medication contributed to the deceased becoming morbidly obese.
5	**CORONER'S CONCERNS** At both primary and secondary health levels it appeared to have been the view that following initial titration and a period of regular checks, annual monitoring for signs of the development of diabetes should be carried out annually as recommended in NICE guideline CG178. However, expert evidence at the inquest suggested that in cases of individuals with a higher risk of developing diabetes, more regular checks were called for. Further there was evidence to the effect that the results of relevant physical healthcare checks had not been shared between primary and secondary healthcare providers. Thus: (1) I draw to the attention of the National Institute for Health and Care Excellence their guidance CG178 and specifically clause 1.3.6.4 thereof and ask them to consider

	whether to the directive for an annual test of inter alia HbA1c, there might be added the words: "or more frequently in those who have a higher baseline risk for the development of diabetes". (2) I draw to the attention of Avon and Wiltshire Mental Health Partnership NHS Trust with reference to their planned review of their document entitled "Medicines Guideline: Monitoring psychotropic medication" my first paragraph addressed to the National Institute for Health and Care Excellence and ask them to consider adding similar wording to their recommendations with regard to annual review appearing at page 4 of the present document. Secondly, I ask the Trust to consider adding advice in the document to the effect that when a patient is prescribed anti-psychotic medication contact be made with the patient's GP practice (a) informing them of this fact (b) requesting communication thereafter of any physical health findings that might indicate serious side-effects or potential side-effects of the drugs and (c) communicating any relevant physical health findings to the GP practice as well as mental health findings.

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 25th January 2020. I, the assistant 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 am sending a copy of my report to the Chief Coroner, the Family of the deceased, [redacted] and Rethink Mental Illness. 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	Dated 28th November 2019 Signature_____ Assistant Coroner for Wiltshire & Swindon