Derek Winter
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Rt Hon Rt Hon Jeremy Hunt** **Secretary of State for Health** **Department of Heath** **Richmond House** **79 Whitehall** **London SW1A 2NS**
1	**CORONER** I am Derek Winter, Senior Coroner for the City of Sunderland
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 07/05/2013 I commenced an investigation into the deaths of May Stokoe (79) and James Henderson Stokoe (79). The investigations concluded at the end of the inquests on 14 January 2014. The conclusions of the inquests were that May Stokoe was killed unlawfully and that James Henderson Stokoe killed himself.
4	**CIRCUMSTANCES OF THE DEATH** On the 1st May 2013 at [redacted] Sunderland May Stokoe was attacked with a knife and sustained fatal injuries and James Henderson Stokoe at the same address by the use of a knife inflicted upon himself fatal injuries.
5	**CORONER'S CONCERNS** During the course of the inquests 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. – Mr and Mrs Stokoe had been married for 56 years. Following Mr Stokoe being diagnosed with bladder cancer he attempted to take his own life which prompted a referral to Mental Health Services. Although there were no reported incidents of domestic violence, it was clear from the evidence before me that the relationship of Mr and Mrs Stokoe was a distant and difficult one. Notwithstanding prescribed medication and the intervention of Mental Health Services, there was an incident on 1st May 2013 at the matrimonial home which led to the unlawful killing of Mrs Stokoe and with Mr Stokoe killing himself. An independent review of the circumstances of the deaths was commissioned by the Northumberland Tyne and Wear NHS Foundation Trust. A number of findings and recommendations were made and I was informed that the Trust accepted them in their entirety and that an action plan would be put in place to progress them. I am concerned to ensure that lessons that have been learnt locally are not lost nationally and I should be grateful if you would confirm that steps will be taken by you to progress matters.

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	I was also concerned about the possibility that carers or partners of individuals who are subject to the provision of Mental Health Services are not formally consulted about the welfare of the patient/service user. Although I was satisfied that domestic abuse awareness was an integral part of training for Mental Health staff, the circumstances of the deaths of Mr and Mrs Stokoe did raise for me concerns that more formal involvement of a carer/partner may allow them to make disclosures which might better inform the assessment process. For example, information from them may corroborate or verify that being provided by the service user/patient. In my view carers/partners may be a very valuable seam of information which may not necessarily be disclosed or volunteered by the service user or patient. Carers/partners should have more visibility to the Mental Health Services and domestic abuse involving the elderly cannot be discounted and matters should be approached with an open mind. I emphasised at the conclusion of the inquests that no one could have predicted the extreme circumstances of the deaths of Mr and Mrs Stokoe and that I was in no way criticising the Trust. Whilst risk cannot be entirely eliminated it would be helpful if you indicate what steps can be taken to improve service provision. I have sent this report to the Home Secretary for her information as the Domestic Homicide Review Report will be progressed very shortly.
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 17 March 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: - - DAC Beachcroft Solicitors on behalf of Northumberland Tyne & Wear NHS Foundation Trust - Scanlans Solicitors on behalf of the family - Home Secretary (for information only) - Care Quality Commission - Domestic Homicide Review Panel - Regulation 28 Archivist for Coroner Society of England and Wales 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 16 January 2014 Signature_____ Senior Coroner for the City of Sunderland