ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. South London and Maudsley NHS Foundation Trust** **2. [redacted] (mother) – [redacted] of Russell-Cooke solicitors** **3. [redacted] (partner)** **4. The Chief Coroner**
1	**CORONER** I am Lorna Tagliavini, assistant coroner, for the coroner area of Inner London South
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 3 April 2013 I commenced an investigation into the death of Moses Andrew Arthur McDonald aged 30 years. The investigation concluded at the end of the inquest on 27 November 2014. The conclusion of the inquest was: "The deceased died as a result of a rare but well-known complication associated with the anti-psychotic medication Clozapine contributed to by a lack of regular glucose testing." The case of death was given by the pathologist as: 1a. Aspiration of stomach content 1b. Diabetic ketoacidosis
	CIRCUMSTANCES OF THE DEATH Mr McDonald had long been diagnosed with Paranoid Schizophrenia. In June 2012 he was prescribed Clozapine in tablet form 150 mg BD and was therefore required to attend for regular blood testing to monitor his white cell count. Mr McDonald regularly attended for these mandatory blood tests and nothing untoward was found. However, his first and last glucose test in May 2012 was recorded at 7.4 and thereafter he was not re-tested for his glucose levels either by the Clozapine clinic or by his GP (having missed his last annual health check-up in February 2013). In March 2013 Mr McDonald complained of frequent urination and extreme thirst whilst on holiday and after his return. On 2 April 2013 Mr McDonald was found deceased at his home address, not having undergone any glucose testing since May 2012.

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. – I am aware of the steps that have already been taken to remedy area of concern in the Level One Investigation Report dated 15 August 2013 (draft). However, this does not address: (1) The lack of mandatory and regular glucose testing while on antipsychotic medication by the Clozapine clinic.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 within 56 days of the date of this report i.e. by 31 January 2015 (excluding Christmas, boxing and New Year's Day). 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 South London and Maudsley NHS Foundation Trust, [redacted] (mother) and [redacted] (partner) 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	**2 December 2014** **LM Tagliavini, assistant coroner**