REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive Pennine Care NHS Foundation Trust
1	CORONER I am Alison Mutch Senior Coroner, for the coroner area of South Manchester
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 15th September 2016 I commenced an investigation into the death of Michael Roy Mahon. The investigation concluded on the 16th February 2017 and the conclusion was one of Narrative: Died as a result of dilated cardiomyopathy, a known complication of obesity and clozapine therapy. The medical cause of death was 1a Dilated cardiomyopathy b Obesity and clozapine therapy c II Alcohol use
4	CIRCUMSTANCES OF THE DEATH Michael Roy Mahon was schizophrenic. He was prescribed clozapine for this. He became obese over a period of time. His overall health deteriorated and he attended the hospital on a number of occasions. On the 13th September 2016 he was at his home address [redacted]. He was seen by his brother at about 8am. Later that morning he was found dead on the sofa by his father.
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. – In the course of the inquest I heard evidence that both annual and monthly tests should be undertaken where clozapine has been prescribed. The annual test was required to identify symptoms and potential side effects that would not necessarily be picked up on monthly tests. Michael Mahon had not had his annual test. This should have taken place in March 2016.It was accepted that there was no system to identify that the test had been missed and it was not noticed at any of his monthly checks.
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 11th May 2017 . 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 namely [redacted], father of the deceased, who may find it useful or of interest. 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	**Alison Mutch OBE** **HM Senior Coroner** **15th March 2017**