ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Oxleas NHS Foundation Trust**
1	**CORONER** I am Philip Barlow, assistant coroner, for the coroner area of Inner South 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 and INQUEST** On 24 July 2017 I commenced an investigation into the death of Michael Vukovic, age 22. The investigation concluded at the end of the inquest on 22 January 2018. The conclusion of the inquest was: Medical cause of death: 1a Hypoxic brain injury due to prolonged cardiac arrest 1b Prolonged cardiac arrest 1c Traumatic L1 vertebral fracture and lumbosacral soft tissue haemorrhage The narrative conclusion was as follows: Mr Vucovic jumped from a building while suffering psychosis.
4	**CIRCUMSTANCES OF THE DEATH** On 8 July 2017 Michael Vukovic, who was suffering psychosis, jumped from a 2nd or 3rd floor balcony and suffered a fracture to the L1 vertebra. He was admitted to Queen Elizabeth Hospital where he suffered a cardiac arrest which caused hypoxic brain damage. He was transferred to Kings College Hospital where he died on 11 July 2017.
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. – At the inquest evidence was given by [redacted] who was at that time a consultant psychiatrist at Oxleas. On 14 March 2017 Mr Vukovic had been admitted to Oxleas under s2 MHA. He was not previously known to services and this was his first psychiatric admission. He was expressing paranoid psychotic symptoms. He was discharged from section on 27 March 2017 and he returned home. Prior to discharge he had been assessed by the Early

	Intervention Service (EIS) but was considered to be ineligible for their service. He was then referred to the Home Treatment Team (HTT) and to Lifeline (a drug and alcohol service). The presumptive diagnosis was that the psychosis was drug/alcohol related, but the evidence was that this could only be confirmed after he had remained abstinent for a period of 4-6 weeks; there was still a possibility that this was a primary psychosis. My specific concerns are as follows: (1) [redacted] evidence was that Mr Vukovic was referred to the Home Treatment Team but was never in fact seen by that team. (2) The referral to Lifeline required Mr Vukovic to make the initial contact himself. He did not do so, and Oxleas did not check whether or not he had done so. The evidence was that if he had been under the care of the HTT he would have been encouraged to engage with Lifeline. (3) The result was that Mr Vukovic was discharged from hospital without follow up.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days, namely by 30 March 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 Mr Vukovic's parents as Interested Persons. I have also sent it to [redacted] of the Metropolitan Police who investigated the death and 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	**29 January 2018** **Philip Barlow**