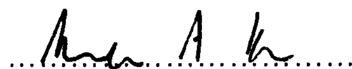
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Neil Carr OBE Chief Executive Midlands Partnership NHS Foundation Trust (MPFT) Trust Headquarters St. George's Hospital Corporation Street Stafford ST16 3SR E-mail: [redacted]
1	**CORONER** I am Mr Andrew Haigh Senior Coroner for the Coroner Area of Staffordshire 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 6th September 2016, I commenced an investigation into the death of Thomas Paul Arthur JACKSON, aged 24 years. The investigation concluded at the end of the inquest on 1st November 2018. The conclusion of the inquest was a detailed narrative one with the Cause of Death being: Ia) Clozapine Toxicity Ib) Pneumonia II) Treatment Resistant Schizophrenia.
4	**CIRCUMSTANCES OF THE DEATH** Tom was subject to compulsory Mental Health Detention at a secure unit within St George's Hospital, Stafford. In the early hours of 25th August 2016 Tom was found in a poorly state in his room. He was certified dead at 02.25 hours.
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:

	(1) During the hearing it was noted that on a number of occasions record keeping was poor. This can make continuity of care difficult and it can lead to matters being missed. I wonder if the Trust can take any action to improve this. (2) It is apparent that patients do benefit from regular 'ward rounds' or 'multi-disciplinary team meetings' (there are a variety of titles) and, apart from the record of these meetings being very poor at times, there is a concern about the conduct of these meetings. In particular there appears to be on occasions inadequate consideration of the history in preparation for the meeting, failure of attendance of all appropriate personnel at such meetings and concern about the patient being able properly to participate. (3) It is clear that Clozapine is a beneficial drug for many patients and that a large number of patients in the care of the Trust do receive this drug. However it appears that many staff are not aware of the significance of this medication particularly when considering potential side-effects and warning signs of deterioration. (4) I would not wish for patients or their families to be overloaded with paperwork but I wonder if there could be a simple leaflet available to patients and family members covering standard information about treatment generally but including matters such as the dangers of patients smoking whilst they are receiving Clozapine. (5) I wonder if there needs to be a review of any lone-working policy or procedure with particular reference as to when to enter patients' rooms. (6) It is well known that it is important for lessons to be learnt following serious incidents. The SIR procedure is a significant part of this. I understand there have been some changes since the time of Tom's death but the SIR carried out in this matter contained a number of significant inaccuracies which can affect the validity of the process. Additionally although the records for patients who are in hospital for a long period of time can become voluminous there has also been some difficulty in disclosure of significant documents during the Inquest process.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 by 8th January 2019. 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: Leigh Day (solicitors representing Tom's mother and sister), [redacted] (Tom's father), Capsticks Solicitors LLP (representing the Midland Partnership NHS Foundation Trust) and Hogan Lovells International LLP (solicitors representing Mylan Product Ltd).

	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	**DATE: 13/11/2018**  Andrew A Haigh HM Senior Coroner for Staffordshire (South) Coroner's Office No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 sscor@staffordshire.gov.uk