REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health and Social Care**
1	**CORONER** I am Catherine McKenna, Area Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 31 August 2021 an investigation into the death of John Abrahams (Jack) was commenced. The investigation concluded at the end of the inquest on 10 February 2023. I recorded a conclusion of Suicide.
4	**CIRCUMSTANCES OF DEATH** Jack Abrahams was 20 years old when he took his own life by means of self-ligature. I heard evidence that when Jack was 17 years old, he had received a six month course of Isotretinoin (brand name Roaccutane) for treatment of acne. The available evidence did not meet the standard required to show a causative link between the course of treatment and Jack's suicide.
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 MATTER OF CONCERN is as follows:- The Commission for Human Medicine (CHM) established an Isotretinoin Expert Working Group (IEWG) in response to concerns about psychiatric events. The IEWG considered oral and written evidence over 2020 and 2021. The findings and recommendations of the IEWG were presented in a report to the CHM at the end of 2021 and include a recommendation which relates to prescribing for patients under the age of 18. It is now over a year since the IEWG report was completed and the recommendations have still not been implemented. In that time there have been 45 adverse Isotretinion events reported to the Medicines Healthcare products Regulatory Agency (MHRA) comprising of 81 psychiatric adverse events, one of which was an attempted suicide. The Court heard that a second working group is required to consider how to implement the IEWG recommendations and that this group has yet to meet.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **12 April 2023**, I, the Area 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:- • The family of Jack Abrahams • The MHRA • [redacted] 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 from. 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.
-	Date: 14 February 2023 Signed: