Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive NHS Derby and Derbyshire Integrated Care Board The Council House First Floor Corporation Street Derby DE1 2FS [redacted] [redacted], Chief Executive National Institute for Health and Care Excellence 3rd floor 3 Piccadilly Place Manchester M1 3BN [redacted]
1	**CORONER** I am Peter Nieto, Senior Coroner for the coroner area of Derby and Derbyshire.
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 17 September 2024 I commenced an investigation into the death of Aaron ATKINSON aged 36. The investigation concluded at the end of the inquest on 29 May 2025. The conclusion of the inquest was: - *Unascertained*
4	**CIRCUMSTANCES OF THE DEATH** Aaron was found deceased on the morning of 20 April 2023 at his home address. His death was completely unexpected. As his cause of death was not known a postmortem examination was conducted including toxicology. The pathologist's opinion was that Aaron had died due to a seizure and positional asphyxia.

	Aaron's mother was doubtful of the cause of death proposed and pressed for a second postmortem which was undertaken by a different pathologist. That pathologist considered that a more likely cause of death was cardiac arrhythmia caused by Aaron's prescription of Risperidone (for behavioural regulation), and Ritalin (for ADHD - attention deficit hyperactivity disorder). On the court's assessment of the evidence, applying the balance of probabilities, a probable medical cause of death cannot be determined. The court notes that Aaron's medication reviews to check for any complications were conducted in line with local health guidelines. Aaron's last review took place in November 2021, but Aaron did not attend subsequent reviews which were offered.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: Whilst Aaron had annual GP reviews related to prescription of anti-psychotic medication (Risperidone, although the inquest heard that prescription of Ritalin was also a relevant factor, particularly in combination with Risperidone), to check for signs of adverse side effects and physical health complications, those reviews did not include ECGs (electrocardiograms) to check for signs of adverse effects on electrical activity of the heart. On the medical evidence before the inquest antipsychotic medication carries recognised risk of QT interval prolongation and lethal cardiac arrhythmias. It does not appear that the recognised risk of QT interval prolongation and lethal cardiac arrhythmias from long term prescription of antipsychotic medication is reflected in guidance to medical practitioners and prescribers, nationally or locally in terms of performing ECGs. The relevant NICE (National Institute for Clinical Excellence) guidance (web link below) refers to ECG testing under *How should I monitor someone taking antipsychotics?* and recommends *Electrocardiography (ECG) - after dose changes. Ideally, also annually.* The local Derbyshire Integrated Care Board guidance (web link below) does not identify need for ECG to be included in annual monitoring in primary care unless *if new medicines or changes to physical health have increased the risk of prolonged QTc arrange ECG.* It appears there is lack of clarity and consistency for annual reviews to include ECGs where people are prescribed antipsychotic medication long term. Given the recognised risks explained at inquest then not providing annual ECGs for long term users of those medications appears to pose risk of death. NICE web link: https://cks.nice.org.uk/topics/bipolar-disorder/prescribing-information/antipsychotics/ Derbyshire web link (DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)): https://www.derbyshiremedicinesmanagement.nhs.uk/assets/Clinical_Guidelines/Formulary_by_BNF_chapter_prescribing_guidelines/BNF_chapter_4/Antipsychotics_Prescribing_and_Management.pdf

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 25 August 2025. 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 • [redacted], mother of Aaron. • [redacted], GP. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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	**Dated: 30 June 2025**  Peter Nieto Senior Coroner Derby and Derbyshire