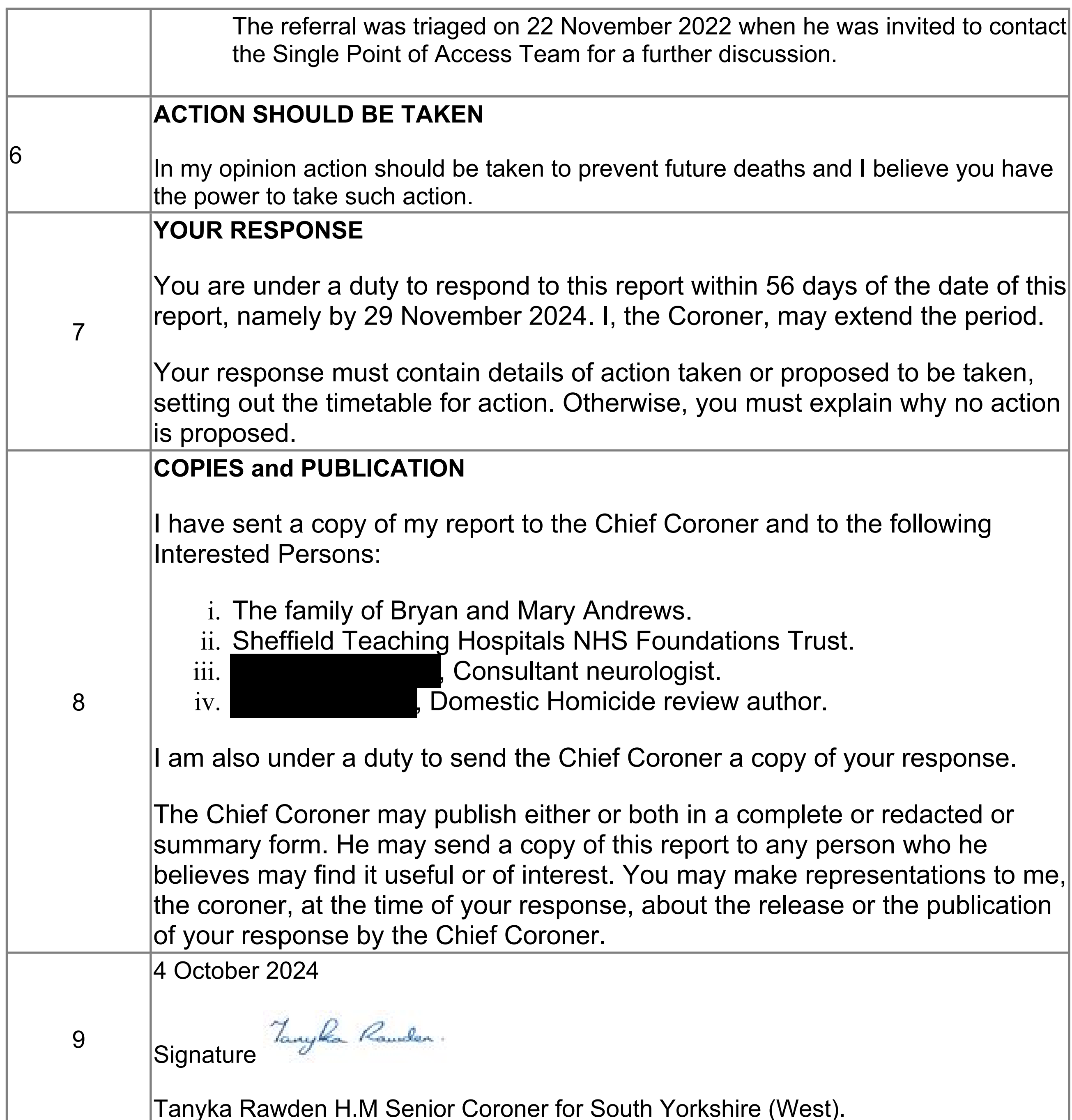
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Sheffield Health and Social Care NHS Foundation Trust.
1	**CORONER** I am Tanyka Rawden, Senior Coroner for the Coroner area of South Yorkshire (West).
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 28 November 2022 I commenced investigations into the deaths of Bryan Andrews aged 79, and Mary Andrews aged 76. The investigation concluded at the end of the inquests on 2 October 2024. The conclusion of the inquests was unlawful killing. The medical cause of death was: 1a. Multiple stab wounds.
4	**CIRCUMSTANCES OF THE DEATH** On 27 November 2022 Bryan and Mary Andrews died at their home address of [redacted] due to multiple stab wounds inflicted by their adult son. Their son had epilepsy caused by an area of abnormal brain development in the right frontal lobe. He continued to have regular seizures despite the medication he was taking. He had a documented history of postictal psychosis. The Court heard his frontal lobe epilepsy created a risk around how he responded to experiences of postictal psychosis. His mental health had deteriorated significantly in the two years before his parents died. Seven months before his parents died, he reported thoughts of wanting to kill someone. In police interview, he admitted to killing his parents and attempting to end his own life by inflicting a knife wound in his abdomen. He pleaded guilty to murder on the grounds of diminished responsibly and was sentenced to an indefinite hospital order.
5	<u>**CORONER'S CONCERNS**</u> During the course of the inquest the evidence revealed matters giving rise to concerns. 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. –

	There was a lack of communication between services about the relationship between the diagnosis of epilepsy and the psychotic symptoms experienced by the person responsible for the deaths. This led to significant time lapses in treatment and rejection of referrals, most notably: i. On 18 November 2020 an urgent referral was made to the Single Point of Access Team by his General Practitioner, concerned about his prolonged suicidal ideation. He was referred back to his General Practitioner by the Single Point of Access Team with a request that the General Practitioner refer him to access the Improving Access to Psychological Therapies Service. ii. On 20 November 2020 his General Practitioner referred him to the Single Point of Access Team again, requesting they liaise with the Improving Access to Psychological Therapies Service as per Trust guidelines. iii. Correspondence between the Improving Access to Psychological Therapies Service and the Single Point of Access Team revealed that whilst the Improving Access to Psychological Therapies Service offered work on living with chronic conditions, they did not have a programme specific to epilepsy. A referral to the Neurology Therapy Service was made and it was decided a request to the General Practitioner for the mental health nurse in the surgery to offer an assessment was appropriate. The surgery were not informed of this. iv. On 16 December 2020 the Single Point of Access Team received a referral from a consultant neurologist requesting a medication review as his anxiety levels were affecting his epilepsy treatment. It was felt that as the General Practitioner was reviewing his medication, a review wasn't required. This was not communicated to the consultant neurologist. v. On 29 April 2022 he called the Single Point of Access Team saying he was having a serious psychotic episode and thought he was going to kill someone. The call was treated as a crisis call during which he decided to attend the emergency department. Once there he was assessed by the Liaison Psychiatry Team. He was referred to the Home Treatment Team, but his consultant neurologist was not informed. vi. On 3 May 2022 a trial of anti-psychotic medication was discussed at a medical review. The required consultant review of whether to prescribe anti-psychotic medication with his epilepsy medication was not carried out. vii. On 4 May 2022 a referral to the Early Intervention Service was rejected as not meeting the criteria for first episode psychosis, despite clear evidence of psychosis in the assessment by the Liaison Psychiatry Team on 29 April 2022 and in subsequent contacts with the Home Treatment Team. viii. On 5 May 2022 a first referral was made to the Emotional Wellbeing Service via email asking for their input into his care. The email was sent to an address not manned daily. When a response was provided it was unclear whether a new treatment episode had been opened. ix. On 09 May 2022 he was discharged from the Home Treatment Team. The discharge was reliant on Emotional Wellbeing Service intervention and a follow up from his General Practitioner. A discharge summary was not sent to his General Practitioner. x. On 4 October 2022 a referral was sent to the Single Point of Access Team by his General Practitioner that he was presenting as paranoid and delusional with suicidal ideation. A screen for urgency found this was a routine referral.



	The referral was triaged on 22 November 2022 when he was invited to contact the Single Point of Access Team for a further discussion.
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 29 November 2024. 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: i. The family of Bryan and Mary Andrews. ii. Sheffield Teaching Hospitals NHS Foundations Trust. iii. , Consultant neurologist. iv. , Domestic Homicide review author. 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	4 October 2024 Signature Tanyka Rawden Tanyka Rawden H.M Senior Coroner for South Yorkshire (West).