Thomas Ralph Osborne
HM Senior Coroner for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Claire Murdoch, Chief Executive Central and North West London NHS Trust**
1	**CORONER** I am Tom Osborne HM Senior Coroner for Milton Keynes
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 02/06/2017 I commenced an investigation into the death of Caroline Antoinette Scott, aged 52. The investigation concluded at the end of the inquest on 17th May 2018. The conclusion of the inquest was a narrative Conclusion: *The deceased suffered from depression and had thoughts of suicide immediately prior to her death and had sought medical advice. It was recognised that she was in crisis but there was a failure to carry out a mental health assessment that resulted in a lost opportunity to refer her for treatment. She was found hanging at her home on 30th May 2017. She was taken by ambulance to Milton Keynes University Hospital where she died on 2nd June 2017.* The cause of death was: 1 (a)Multi Organ Failure 1 (b) Hypoxic Brain Injury following Hanging 2. Depression
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered a head injury in 2009, leading to depression for approximately 10 years, She had made previous attempts at suicide and was considered high risk. On 30th May 2017, she was found by family hanging in the garage. An ambulance was called and she was cut down and CPR commenced. She was transferred to Milton Keynes Hospital where she was treated until she passed away on 2nd June 2017. In the weeks leading up to her death, she had contact with her GP, the accident and emergency department and the out of hours service.
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) That the provision of out of hours emergency service for mental health emergencies is inadequate (2) That the policy for emergency referrals is not fully understood by all medical services in Milton Keynes

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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 15th July 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 following Interested Persons: - The Family of the deceased - Milton Keynes University Hospital - Milton Keynes Urgent Care Services - Parkside Medical Centre I have also sent it to Milton Keynes Clinical Commissioning Group who 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	Dated 21st May 2018 Signature_____ HM Senior Coroner for Milton Keynes

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