Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO: :

Matthew Webb, Chief Officer
Milton Keynes Clinical Commissioning Group
Sherwood Drive
Milton Keynes MK3 6RT

1 CORONER

I am Thomas R Osborne, HM Senior Coroner for the area of Milton KeyneMilton 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.

3 INVESTIGATION and INQUEST

On 11/07/2017 I commenced an investigation into the death of Billie Johnathan LORD aged 26. The investigation concluded at the end of the inquest on 26th October 2018. The conclusion of the inquest was a narrative conclusion as follows:

Billie Lord died from suicide whilst suffering from psychosis.

He suffered from autism and a psychotic illness caused by the use of non-prescription drugs including cannabis. He was referred to the Milton Keynes Crisis team and came under the care of the Acute Home Treatment Team who saw him daily from 5th July 2017. On the 9th July 2017 he was admitted to the Campbell Centre in Milton Keynes as a voluntary patient after being arrested for an assault upon his mother. He was assessed and monitored by intermittent 15 minute observations on Hazel Ward until he absconded at 04.30am on 11th July 2017 by breaking a window with a toilet that he wrenched from the wall. He climbed onto the railway line at Denbigh Hall and ran into the path of a high speed train at 08.40 and died from his resulting injuries.

4 CIRCUMSTANCES OF THE DEATH

See Narrative conclusion above.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

During the course of the evidence I was informed by an independent expert that it is recognised that patients admitted to an in-patient mental health facility, such as the Campbell Centre, should be cared for in single rooms and that three bedded dormitory accommodation is inappropriate since in this particular case it added to the level of stress suffered by the patient. Consideration should be given to a review of the accommodation provided at the Campbell Centre, and whether alterations can be carried out to bring the accommodation up to modern standards as recommended by the Royal College of Psychiatrists.

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 27th December 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 Mr Lord
Central North West London NHS Foundation Trust

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.

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Tom OSBORNE
Senior Coroner for
Milton Keynes
Dated: 01 November 2018