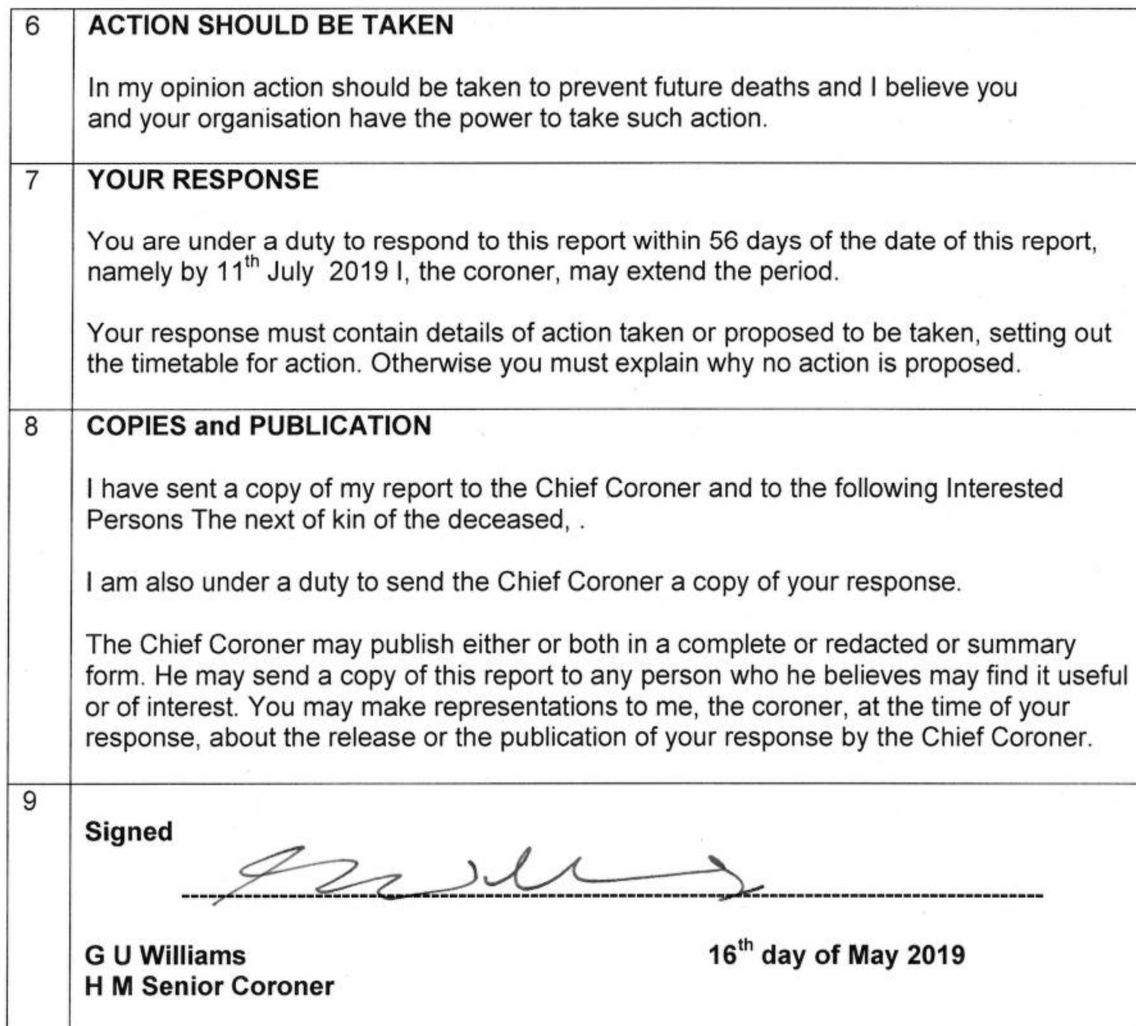
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Worcestershire Acute Hospitals NHS Trust** 2. 3.
1	**CORONER** I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire
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 31st of January 2019 I commenced an investigation into the death of Kevin John McDonald then aged 53 years. The investigation concluded at the end of the inquest on 16th of May 2019. The conclusion of the inquest was A case of suicide the medical cause of death being Exsanguination caused by multiple incised wounds .
4	**CIRCUMSTANCES OF THE DEATH** Mr McDonald was admitted into the Alexandra Hospital in Redditch following a spinal injury where he was assessed and quickly discharged with analgesia but apparently no follow-up. He later killed himself leaving a note indicating that he was doing so because he could no longer stand the pain
5	**<u>CORONER'S CONCERNS</u>** 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) During the inquest the clinician giving evidence indicated that the discharge paperwork from the clinical decision-making unit is different to that from other wards/departments and it is not clear what a follow-up or advice/guidance is given to patients. The family of the deceased contend that there was no advice or follow-up and that the deceased was left not knowing what to do about his increasing pain. It appears that no documentation has been found within the hospital about this The standardisation of discharge documentation would appear to be in need of review and I invite you to consider this. (2) (3)



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 11th July 2019 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 next of kin of the deceased, . 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	**Signed** -- **G U Williams** **16th day of May 2019** **H M Senior Coroner**