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:

1 Chief Executive Milton Keynes Council
2 Director Social Services

1 CORONER

I am Tom OSBORNE, Senior Coroner for the area of 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.

3 INVESTIGATION and INQUEST

On 27/08/2019 12:53 I commenced an investigation into the death of Roy Adrian CURTIS aged 28. The investigation concluded at the end of the inquest on 02 December 2020. The conclusion of the inquest was:
The deceased who was diagnosed with an autistic spectrum condition in 2012 was admitted to the Campbell Centre in Milton Keynes on the 13th of September 2018 after declaring his intention to take his own life. He was discharged from the Campbell Centre and then from the home treatment team without a formal multidisciplinary discharge plan. There was also, a failure to complete an adult social care assessment that resulted in a lost opportunity to assess his needs and offer him support. He died from suicide by hanging himself on or about the 18th of November 2018 And his body was discovered on the 21st of August 2019 at [redacted] Ashland Milton Keynes.

4 CIRCUMSTANCES OF THE DEATH
See narrative

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:
That the procedure for allocating and responding to a referral for an urgent adult social care assessment is overly bureaucratic and they are not afforded the priority within social services that they so obviously require.

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 28 January 2021. 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

CNWL
FAMILY

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

Tom OSBORNE
Senior Coroner for
Milton Keynes
Dated: 04 December 2020