**Thomas Ralph Osborne**
**Senior Coroner for Milton Keynes**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:** Chief Executive Officer Oxford University Hospitals, [redacted] |
| 1 | **CORONER**<br><br>I am Thomas Ralph Osborne, Senior Coroner for Milton Keynes |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 14th December 2015 I commenced an investigation into the death of James Francis Flynn, 68. The investigation concluded at the end of the inquest on 25th October 2016. The conclusion of the inquest was a narrative conclusion as attached. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>The deceased suffered from Chronic Pancreatitis. He was last seen by his GP on 12th November 2015 with acute pancreatitis and was admitted to Milton Keynes Hospital. Mr Flynn was later referred on to the John Radcliffe Hospital where he was treated. He was discharged home on the 8th December 2015 arriving at 2058 in the evening.<br>At 1715 on 9th December his family attended but could not gain access to the house, they went to the rear of the property and saw Mr Flynn knelt face down on the floor of his ground floor bedroom. The police forced entry and Mr Flynn was found unresponsive; CPR was commenced until the paramedic confirmed death at 1806. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) That an elderly patient who was still very unwell was discharged home very late in the evening without a detailed care plan being in place, His immediate family were unaware of the discharge and there was no food or provision for him in the house despite being a type 2 diabetic.<br>(2) Inadequate planning and management of patient discharge will put patients lives at risk. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 26th December 2016. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [redacted], his son. I have also sent it to [redacted] the GP and to the CQC who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 31st October 2016<br><br>Signature_____<br>Senior Coroner for Milton Keynes |

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