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 Claire Murdoch, Chief Executive of Central Northwest London NHS Foundation Trust

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 23/01/2019 I commenced an investigation into the death of Iain Neil MACINNES aged 65. The investigation concluded at the end of the inquest on 31st July 2019. The conclusion of the inquest was: Narrative conclusion:

The deceased's mental health began to deteriorate throughout December 2018 and his care was transferred to the Acute Home Treatment Team although this was not communicated to his family. There was a failure to recognise the extent of his deterioration that resulted in lost opportunities to admit him to hospital for further treatment and he was found hanging at [redacted] Milton Keynes on 17th January 2019.

4 CIRCUMSTANCES OF THE DEATH

The deceased was found hanging in his home at [redacted] Milton Keynes on the 17th January 2019

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

During the course of the evidence it became apparent that, despite the fact that the deceased had indicated that he wanted information to be shared with his family and for them to be involved in his care, they were not informed that his condition had deteriorated and that he had been transferred to the Home Treatment Team although it was widely accepted that it is important that the family are involved in a patients treatment and care. The process for recording details of the family and for keeping them informed needs to be reviewed by the trust and proposals for reform considered.

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 18th November 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 family of Mr Macinnes

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: 24 September 2019