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, 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 23/01/2018 I commenced an investigation into the death of Colette Denise Vivienne Jean DUNN aged 50. The investigation concluded at the end of the inquest on 19th October 2018. The conclusion of the inquest was:

Colette Dunn died from Suicide. She was discharged from Milton Keynes University Hospital by the Mental Health Liaison Team at 14.10 on 22nd January 2018. She had been taken to the hospital by ambulance accompanied by police officers who remained with her throughout because she was threatening to kill herself. She did not have a formal Mental Health Act Assessment prior to discharge and this resulted in a lost opportunity to detain her formally. She, later that afternoon, doused herself with petrol and set fire to herself sustaining severe burns. She died at 05.14 0n 23rd January 2018.

4 CIRCUMSTANCES OF THE DEATH

See above

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

1. During the course of the evidence it was clear that prior to discharge from the hospital a full Mental Health Act assessment by a psychiatrist should have been carried out before the decision was taken to discharge Ms Dunn, particularly as the police officers were expressing their concerns to the staff that Ms Dunn had indicated that once she had left the hospital it was her intention to kill herself and indicated that she would tell the staff what they wanted to hear in order to secure her discharge.
2. That there needs to be a clear and agreed protocol between the police, the hospital and the CNWL NHS trust as to how the discharge of patients brought in for assessment is going to be dealt with.
3. There does not appear to be any facility within Milton Keynes for dealing effectively with patients suffering a mental health crisis to ensure they are brought to the hospital for assessment and treatment.

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
Central North West London NHS Foundation Trust
Yvette Hitch – TVP Local Area Police Commander for Milton Keynes

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: 01 November 2018