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 :

Michael Bracey, Chief Executive Milton Keynes Council

And

[redacted], Chief Operating Officer Milton Keynes Central Commissioning Group

1 CORONER

I am Thomas R Osborne, Senior Coroner for 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 16/07/2018 I commenced an investigation into the death of Neil Stephen David SWAISLAND aged 49. The investigation concluded at the end of the inquest on 28th November 2018. The conclusion of the inquest was: Suicide

4 CIRCUMSTANCES OF THE DEATH

The deceased went to the top floor of the multi storey car park situated in Cresswell Lane, Milton Keynes at 12.50 on 14th July 2018 and jumped to the ground below sustaining multiple injuries. He was confirmed dead at the scene at 13.51 the same day.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows :
During the course of the evidence I heard from a senior GP from Milton Keynes and from a senior clinician from mental health services that the funding for counselling services operated by MIND had been withdrawn by both the Council and the CCG. They expressed the view that as a result of this decision it is inevitable that further lives will be put at risk from self-harm and suicide. My concern is that the decision not to provide counselling to some of the very vulnerable people within our society will result in further deaths from suicide.

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 by reviewing the provision of counselling services in Milton Keynes.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 5th February 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
Milton Keynes University Hospital,
Central and North West London NHS Trust
The Family of Mr Swaisland

I have also sent a copy to MIND, The GP Practice and Compass who may find it useful or of interest.

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: 12 December 2018