Thomas Ralph Osborne
Senior Coroner for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Mr Tom Riall, Chief Executive Officer, The Priory Group**
1	**CORONER** I am Thomas Ralph 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 08/12/2015 I commenced an investigation into the death of Anthony Thomas McManus, 48. The investigation concluded at the end of the inquest on 7th October 2016. The conclusion of the inquest was a detailed narrative conclusion. See attached.
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from a personality disorder and learning difficulties, he was detained under Section 37 of the Mental Health Act. He had been a resident at Chadwick Lodge for a number of years. He was on a standard regime, hourly checks. On 08/12/2015 he was checked at 0200 and not visible. He was then checked again at 0300 and was still not visible so staff entered his room and found him hanging from the back of the bathroom door using a draw string bag. His death was confirmed at 0338.
5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows. – (1) The system of observations carried out within the unit, particularly at night is in need of reform. (2) Many of the nurses were conducting hourly observations every hour at the same time each hour, rather than randomly. (3) Some observations were not carried out and the observation chart completed at the end of the shift. (4) A robust system of observations should be considered.

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6	**ACTION SHOULD BE TAKEN** 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** 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. 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 McManus I have also sent it to the CQC 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	Dated 31st October 2016 Signature__________________________ Senior Coroner for Milton Keynes