REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Group Executive Director of Workforce and Corporate Business, Manchester University NHS Foundation Trust

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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

INVESTIGATION and INQUEST

On 29th September 2021, an inquest was opened into the death of Dr Lee Winslow, who died at his home on 12th June 2021, aged 56 years. The investigation concluded at the end of the inquest which I heard on 28th July 2022.

The inquest determined that Dr Winslow died as a consequence of [redacted] toxicity. The conclusion of the inquest as to Dr Winslow's death was one of Suicide.

CIRCUMSTANCES OF THE DEATH

Dr Winslow was found dead at his home on 12th June 2021 having taken [redacted] with the intention of ending his life. The inquest determined that, whilst the [redacted] had probably been taken from one of the hospitals where he worked, the [redacted] had been taken from Manchester Royal Infirmary.

In August 2020, Dr Winslow had previously attempted to end his life by taking an overdose of [redacted] Aside from the [redacted] which had been left over from a previous prescription, Dr Winslow freely admitted having taken the remainder of these medicines from Trust stocks.

Following this overdose, Dr Winslow was absent from the Trust on sick-leave until 14th December 2020. After a period of supervised practice, Dr Winslow returned to unrestricted duties in the week commencing 18th January.

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. Following the admission by Dr Winslow in 2020 that he had taken medicines from the Trust with a view to ending his life, it is a matter of concern that the case was not formally referred to the Police and the General Medical Council.

   Making such referrals would have had the potential benefit of:-

   i) Providing the Trust with ready access to external advice as to the adequacy (or otherwise) of steps taken to mitigate the future risk of staff members misappropriating medicines with a view to self-harming; and

   ii) Offered access to a mechanism whereby objective analysis of Dr Winslow's fitness to practise as a Consultant Anaesthetist (both from a health and broader perspective) could have taken place;

2. In December 2020, the Trust became aware that, whilst on sick leave from the NHS, Dr Winslow had continued with his private practice notwithstanding an explicit instruction from his manager to the effect that he should refrain from all work. It is a further matter of concern that this development did not, of itself, cause the Trust to reconsider its position and make the referrals set out above;

3. In the absence of any meaningful external review of the case as a whole, it is a particular concern that most of the actions which followed the theft of medication by Dr Winslow in 2020 appear to have been taken as a result of decisions made by members of the Trust's medical hierarchy.

   In view of the gravity of the issues raised by Dr Winslow's misappropriation of drugs in 2020, and the previous suicide of a Consultant Anaesthetist employed by the Trust involving misuse of prescription medicines, it is a matter of concern that a more multi-disciplinary approach was not taken, perhaps overseen by someone such as a non-executive director of the organisation.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th October 2022. 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted] on behalf of Dr Winslow's family.

I have sent a copy of my report to the General Medical Council, the Care Quality Commission and NHS England, 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.

Dated: 17th August 2022

Signature: 

Chris Morris HM Area Coroner, Manchester South.