Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Milton Keynes University Hospital** **2 Central North West London NHS Foundation Trust**
1	**CORONER** I am Tom OSBORNE, Senior Coroner for the coroner 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 21 September 2022 I commenced an investigation into the death of Ronald Alfred KELLY aged 91. The investigation concluded at the end of the inquest on 10 November 2022. The conclusion of the inquest was that Mr Kelly died from suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was found hanging [redacted] on 19th of September 2022. He had recently been discharged from hospital and was struggling to cope.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 1. That a 91-year-old man was discharged from hospital following surgery, having refused to wait over the weekend for a care package to be put in place and there was no follow-up arranged to either assist him with his care or to ensure that he was coping. 2. That when the GP practice made a subsequent referral for a visit and assessment by the district nurse it was rejected on the basis that the appropriate referral was to "home first". The GP forwarded the referral but nothing was actioned. 3. There does not appear to be any system to ensure that a patient discharged home possibly needing support and care are automatically followed up.
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 January 10, 2023. 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 Kelly** I have also sent it to **Purbeck Health Centre** **MK Together Partnership** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 15/11/2022**  **Tom OSBORNE** **Senior Coroner for** **Milton Keynes**