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 Chief Executive - John Radcliffe Hospital** **2 MK Together Partnership**
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 29 June 2022 I commenced an investigation into the death of David WOOD aged 56. The investigation concluded at the end of the inquest on 06 December 2022. The conclusion of the inquest was that: The deceased having recently undergone open heart surgery in Oxford developed a severe depression. He was found on 22nd June 2022 hanging at his home [redacted] Milton Keynes.
4	**CIRCUMSTANCES OF THE DEATH** Mr. Wood had been suffering from depression and difficulty sleeping following his release from hospital after the surgery. He had been to see his doctor about this. On Wednesday the 22nd of June 2022 Mr. Wood was at home with his wife. During the afternoon Mrs. Wood went out leaving him sat in a downstairs chair. On her return he was no longer in the chair and she thought that he had gone upstairs to try and sleep. Later that evening at 8pm she went to wake him up. Mrs Wood found him suspended by the neck.
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) Following the death of Mr. Wood a review was conducted by the trust and the review recognised that it would have been helpful if the symptoms of delirium had been highlighted to the GP and that it would have been useful if there had been a discussion with Mrs Wood to educate her as to the possibility of delirium, and to help plan his discharge from hospital and inform her when she should seek further medical assistance, The protocols for discharge following heart surgery should be reviewed in order to prevent

	similar deaths.
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 August 01, 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 I have also sent it to 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: 07/06/2023** **Tom OSBORNE** **Senior Coroner for** **Milton Keynes**