MR G IRVINE
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted], Managing Director, The Cambridge Nursing Home Ltd [redacted] **2.** [redacted], Interim Chief Executive, London Borough of Redbridge [redacted] **3.** [redacted], Chief Executive Officer, The Integrated Care Board (ICB) for North-East London [redacted] **4.** [redacted], The Evergreen Surgery, Wanstead [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East London
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 9th November 2023 this court commenced an investigation into the death of Mark Wolfe Kinzley aged 61 years. The investigation concluded at the end of the inquest on 26th March 2024. The court returned a narrative conclusion.

	"*Mark Wolfe Kinzley died in hospital on 1st November 2023 due to complications of injuries sustained on 30th October 2023 in his nursing home when he suspended himself from a ligature* [redacted] *. It has not been possible to determine his intentions at the time of the suspension."* Mr Kinzley's medical cause of death was determined as; 1a Hypoxic-ischaemic brain damage 1b Asphyxia
4	**CIRCUMSTANCES OF THE DEATH** Mark Wolfe Kinzley was a frail 61 yr old man who suffered from a neurological disorder, Dandy-Walker Syndrome. This congenital disorder presented itself in symptoms of cerebellar ataxia which limited his mobility, speech and continence. Mr Kinzley had recently developed seizure activity. Mr Kinzley had a history of mental health problems having been diagnosed with anxiety and depression. On at least two previous occasions Mr Kinzley had attempted self-harm by overdose, on one of those occasions he was admitted for inpatient mental health treatment. Mr Kinzley was known to have periodic episodes of aggressive and irritable behaviour, marked by utterances of frustration and accidental self-harm due to high-risk behaviours. In January of 2023 following a hospital admission due to physical symptoms of self-neglect, Mr Kinzley was discharged to a nursing home funded by the local authority. The nursing home was typically occupied by elderly persons receiving end of life care. Concerns lay as to the extent of Mr Kinzley's capacity and a DOLS (deprivation of liberty standards) order had been applied for, but not finalised with the local authority. Mr Kinzley was socially isolated, during his 10-month residence at the nursing home he received neither a visit nor a telephone call from a relative or friend. In the months leading to Mr Kinzley's death he was noted by carers at the nursing home to have experienced episodes of agitation at an increased level of frequency and acuity. Mark was observed on multiple occasions to be "sad"," agitated"," angry" & "trying to hit/injure self". These episodes accelerated in the week prior to his death. On the morning of 30th October 2023 he was found unresponsive in his bedroom, suspended by a coat hanger around his neck, attached to his door handle. Despite the best efforts of carers and the emergency services he later died in hospital from his injuries.

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 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. – 1. I have doubts that the location of Mr Kinzley's care was appropriate. Mr Kinzley was a socially isolated adult suffering from a profound neurological disorder and mental illness. 2. No formal assessment of Mr Kinzley's capacity was undertaken whilst a resident at the nursing home. Such an assessment may have resulted in an advocate acting as his voice in his best interests. 3. During the same period, Mr Kinzley was not referred for a mental health assessment despite. a. His history of mental illness. b. His history of deliberate self-harm. c. His history of accidental self-harm when agitated. d. His deteriorating mental state during the month prior to his death.
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 **22nd May 2024**. 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 Kinzley and the Care Quality Commission. I have e also sent it to the local Director of Public Health 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 other 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.
9	**[DATE] 26th March 2024 [SIGNED BY CORONER]**