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 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 26 January 2024 I commenced an investigation into the death of Florence Elizabeth Catherine STEWART aged 27. The investigation concluded at the end of the inquest on 09 October 2024. The conclusion of the inquest was that: Narrative conclusion Narrative conclusion - suicide whilst suffering from mental illness having been admitted as a voluntary patient to the campbell centre milton keynes following her detention under s. 136 of the mental health act, after an incident when she was assaulted on 18th january 2014.
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from mental illness and was admitted to the Campbell Centre in Milton Keynes as a voluntary patient following her detention under S.136 of the Mental Health Act after an incident when she was assaulted om 18th January 2024. When an inpatient she was subject to high level intermittent observations. She [redacted] but this was unknown to members of staff. The observations were not carried out efficiently and the detection of her hanging was delayed. She hanged herself [redacted] and suffered a hypoxic brain injury on the 20th January 2024. When found she was attached to a defibrillator the pads were incorrectly placed. She was given oxygen but the oxygen bottle ran out of oxygen during resuscitation. She died at Milton Keynes University Hospital on 23rd January 2024.
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) Firstly that the system of high level intermittent observations failed to prevent Florence's suicide and needs a fundamental review. Secondly, that the Oxygen bottle used during resuscitation ran out of oxygen.

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 December 05, 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 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: 10/10/2024**  **Tom OSBORNE** **Senior Coroner for** **Milton Keynes**