REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Priory Group**
1	**CORONER** I am Joanne Kearsley, Area Coroner, for the coroner area of South Manchester
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 13th February 2014 I commenced an investigation into the death of Mark Hancock dob 25.09.1971. The investigation concluded on the 27th October and the conclusion was one that the deceased had taken his own life. The medical cause of death was recorded as 1a) Multiple Incised Wounds
4	**CIRCUMSTANCES OF THE DEATH** I heard evidence that the deceased had a history of mental health difficulties. His condition had deteriorated towards the end of 2013. He was receiving treatment at the Priory Hospital and had a diagnosis of severe clinical depression. Following his diagnosis he was treated with medication and therapy. On the 8th February the deceased had superficially cut his wrists. This had not required any medical intervention. On the 11th February 2014 he was attending the therapy group and at the lunch time had an appointment with his Consultant. During the course of the morning it had been noted by his therapist that the deceased was presenting differently. He was withdrawn and not participating. He was then seen by his Consultant who concluded that the deceased required hospital admission. There were no beds available due to an incident on the ward. A decision was taken that the deceased could return home to his parents' house and would be admitted the following day. On his return to the afternoon therapy session there was increased concern by the therapist who escalated his concerns about the deceased. There was then a further discussion with his consultant but the plan remained the same. The deceased returned home to his parents' house where he appeared settled. In the early hours of the 12th February 2014 he was found by his parents to have smashed a glass and inflicted a number of serious wounds to himself particularly to his throat and thigh.
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 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. – - The quality of the records kept in relation to the deceased was poor and in some circumstances non-existent. No records were kept of the Multi-Disciplinary Team Meetings. - The Consultant notes were brief and are not kept on the Care Notes system. Such a diverse practice means that there is no overall record of a patient so that all those who have involvement with a patient do not have all relevant, pertinent information available to them. - No documented risk assessment was completed in relation to the risk the deceased posed to himself. - No further assessment of the deceased was undertaken by the Consultant after concerns had been escalated following his departure from the group therapy. - The consultant's out-patient appointment with the deceased had been booked to take place in the lunchtime when he was already in a full day therapy session. - When concerns were raised in relation to the deceased the further discussions took place in the reception area, an inappropriate environment in which to speak to a patient and obtain important information. - Given there was no formal risk assessment there was no consideration as to whether the risk management plan was appropriate. - There was no procedure or policy in place for staff as to what they should do if a patient requires admission but a bed is not available.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 5 January 2015. 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 namely . I have also sent it to Greater Manchester Police 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.
9	**Date 10/11/2014** **Joanne Kearsley HM Area Coroner Manchester South**