REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Mr Trevor Torrington, Chief Executive, The Priory Hospital, Altrincham, Rappax Road, Hale, Cheshire, WA15 0NX **2.** [redacted] Consultant Psychiatrist, The Priory Hospital, Altrincham, Rappax Road, Hale, Cheshire, WA15 0NX
1	**CORONER** I am Alan Peter Walsh, Area Coroner, for the Coroner Area of Manchester West
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 the 6th January 2015 I commenced an Investigation into the death of Suzanne Samantha Greenwood, 43 years, born 14th August 1971. The Investigation concluded at the end of the Inquest on the 8th October 2015. The medical cause of death was 1a) Hanging The conclusion of the inquest was open.
4	**CIRCUMSTANCES OF THE DEATH** 1. Suzanne Samantha Greenwood died at Haslam Park, Wigan Road, Bolton on the 23rd December 2014 when she was found in a collapsed and unresponsive condition with a ligature around her neck and attached to the branch of a tree. She had taken a substantial quantity of Zopiclone and a quantity of alcohol prior to her death. 2. Mrs Greenwood had received treatment from the Mental Health services within the Greater Manchester West Mental Health NHS Foundation Trust in 2002 following a referral from her General Practitioner and in 2005 after she attended the Royal Bolton Hospital Emergency Department. 3. In October 2012 Mrs Greenwood self-referred to the Priory Hospital, Altrincham, Rappax Road, Hale, Cheshire as a private patient and she was seen by [redacted] Consultant Psychiatrist, on the 5th October 2012. She informed [redacted] that she had started to use

Zopiclone in 2005 for sleep problems and she had started to purchase Zopiclone online by use of the internet in 2007.

Mrs Greenwood was diagnosed as suffering with mental and behavioural disorders due to the use of sedatives and hypnotics (Zopiclone) dependence syndrome and moderate depressive episodes. She was admitted to the Priory Hospital, Altrincham on the 5th October 2012 and she received treatment until she was discharged on 29th October 2012 with a plan for her to attend an aftercare programme at the Hospital.

4. Mrs Greenwood attended review appointments with [redacted] at the Priory Hospital, Altrincham from the time of her discharge until 21st November 2013.

   On the 31st October 2013 [redacted] saw Mrs Greenwood in his outpatient clinic and she reported that her mood had been quite low over the previous 6 weeks and she had been tearful at times. She reported that her sleep had not been good and that she had seen a hypnotherapist to improve her sleep. [redacted] increased her medication and arranged to see her again on 21st November 2013.

   On the 21st November 2013 [redacted] saw Mrs Greenwood at the Priory Hospital, Altrincham and he recorded that Mrs Greenwood had been alot better during the previous week and that there had been an improvement in her mood. [redacted] completed a mental state examination and recorded that Mrs Greenwood's general self-care was good. She was alert her speech was normal. Her mood was euthymic and she had no negative depressive cognitions. [redacted] advised that her medication should continue and he made arrangements to review her in six weeks' time. [redacted] sent a letter dated 22nd November 2013 to Mrs Greenwood's General Practitioner to confirm the details of the review on the 21st November 2013.

5. Mrs Greenwood was given an appointment with [redacted] at The Priory Hospital, Altrincham on 9th January 2014 but she cancelled her appointment, which was rearranged for 16th January 2014 but she failed to attend on that date. There was no further contact between [redacted] and Mrs Greenwood between January 2014 and the 23rd December 2014 when Mrs Greenwood died.

6. [redacted] gave evidence at the Inquest that he had a Secretary at The Priory Hospital, Altrincham who was employed by the Hospital. He confirmed that he was a private Consultant Psychiatrist who worked at The Priory Hospital, Altrincham and he was subject to the protocols and policies of the Hospital.

   He confirmed that, when a patient failed to attend an appointment, his Secretary would usually make contact with the patient to rearrange the appointment. However there was no evidence of any contact with Mrs Greenwood, either by telephone or letter, after she failed to attend the appointment on 16th January 2014 and he had not discharged Mrs Greenwood from his care prior to her death on the 23rd December 2014.

[redacted] confirmed that there had been no contact, either by telephone or letter, with Mrs Greenwood's General Practitioner to confirm that she had failed to attend her appointments in January 2014 and the General Practitioner had not been informed that Mrs Greenwood had not been seen following her last appointment on the 21st November 2013. In fact the letter sent to the General Practitioner by [redacted] dated 22nd November 2013 referred to a review on the 21st October 2013, which was clearly an error due to the fact that the review had taken place on the 21st November 2013.

7. [redacted] gave evidence that he was not aware, either in his own practice or in the Priory Hospital, Altrincham, that there were any policies or protocols in relation to a system to apply when a patient failed to attend an appointment. Furthermore there was no system in relation to contact with a patient when the patient failed to attend an appointment, either to arrange a further appointment or to consider discharge of the patient for repeated failures to attend appointments, and there we no systems in place to contact either General Practitioners or other health professionals who may be continuing to treat a patient. [redacted] confirmed that there was no timescale with regard to contact with a patient to rearrange a missed or cancelled appointment nor any timescale with regard to the discharge of a patient when a patient had repeatedly failed to attend appointments.

8. The evidence at the Inquest from the General Practitioner was that there had been further appointments with the General Practitioner after November 2013, including a change in the dose of medication initially prescribed by [redacted], without the General Practitioner being aware as to whether [redacted] was continuing to treat Mrs Greenwood. In fact the evidence from an Advanced Nurse Practitioner at the Inquest confirmed that Mrs Greenwood was seen by her in the General Practitioner's surgery on the 20th November 2014 when the Advanced Nurse Practitioner reduced Mrs Greenwood's medication and the Advanced Nurse Practitioner was not aware that her treatment by [redacted] at the Priory Hospital, Altrincham was still open and that she had not been discharged. The appointment with the Advanced Nurse Practitioner on the 20th November 2014 was almost 12 months after Mrs Greenwoods last appointment with [redacted] on the 21st November 2013.

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:

1. During the Inquest evidence was heard that

   i. Mrs Greenwood had not been seen by [redacted] at The Priory Hospital, Altrincham after her last review on the 21st November

2013 prior to her death on the 23rd December 2014. She had failed to attend appointments in January 2014 but there had been no contact with her, either by telephone or letter, following her failure to attend the appointment on the 16th January 2014.

ii. Mrs Greenwood had not been discharged by [redacted] following her failure to attend her appointment on the 16th January 2014 and before her death on the 23rd December 2014 but there had been no contact with her for a period exceeding 11 months.

iii. [redacted] had not made any contact with the General Practitioner to confirm Mrs Greenwood's failure to attend her appointments in January 2014 and that she had not been seen after the 21st November 2013, which is a particular concern when an Advanced Nurse Practitioner reduced the medication initially prescribed by [redacted] which she had the authority to reduce, in circumstances where [redacted] had not seen Mrs Greenwood since the 21st November 2013.

iv. There are no systems, either in [redacted] private practice or in the Priory Hospital, Altrincham to contact patients following a failure to attend appointments and to consider the discharge of patients when a patient repeatedly fails to attend appointments over a period of time. There are no timescales with regard to the discharge of patients and no system to contact General Practitioners or other health professionals in relation to the failure to attend appointments, particularly in circumstances where other health professionals are likely to continue to treat patients after the missed appointments, including changes in medication.

The importance of discharge within a reasonable period after a failure to attend appointments is important to enable other health professionals involved in continuing care to be aware of the non-attendance at appointments and the discharge. The fact that there has been no reported failure to attend appointments and no reported discharge would be misleading to other health professionals involved in continuing care, particularly when a patient has not been seen for a period in excess of 12 months and that information would not be available to other health professionals in the absence of information from the Hospital.

There is a need for health professionals involved in the continuing care of a patient to be kept informed as to the treatment or non-treatment of the patient at a Hospital when considering further treatment in the community.

2. I request you to consider the above concerns and for both [redacted] and The Priory Hospital, Altrincham to carry out a review with regard to the following.

i. The systems procedures, policies and protocols in relation to contact with patients who fail to attend appointments.

	ii. The systems, procedures, policies and protocols in relation to patients who repeatedly fail to attend appointments and to consider a final letter to the patient indicating that the patient will be discharged unless there is either contact or an appointment within a defined period. iii. The systems, procedures, policies and protocols in relation to the discharge of patients who repeatedly fail to attend appointments with notification to General Practitioners or other health professionals of the patient's failure to attend appointments and their discharge from hospital. The review should consider timescales in relation to discharge when a patient has failed to attend appointments for a specific period of time. iv. The evidence raised concerns that there is a risk that future deaths will occur unless action is taken to review the above issues.
	ACTION SHOULD BE TAKEN In my opinion urgent action should be taken to prevent future deaths and I believe you and 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 4th December 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: 1. [redacted], Mrs Greenwood's Husband 2. Express Solicitors, Solicitors for and on behalf of David Greenwood 3. [redacted] Mrs Greenwood's sister 4. [redacted], Mrs Greenwood's Sister 5. [redacted], Mrs Greenwood's Brother 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	**Dated** **9th October 2015**	**Signed** **Mr Alan P Walsh**