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. Chief Executive - Oxleas NHS Foundation Trust.** **2. The Director – The Priory Hospital Ticehurst House.** **3. Secretary of State for Health, Department of Health.** **4. The Care Quality Commission.** **5. The Chief Coroner.**
1	**CORONER** I am Christopher Williams an assistant coroner, for the coroner area of Inner London South (Southwark Coroners Court).
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/uksi/2013/1629/regulation/28/made and http://www.legislation.gov.uk/uksi/2013/1629/regulation/29/made
3	**INVESTIGATION and INQUEST** An investigation into the death of **Anne Morris** commenced on the 28/6/2017. The investigation concluded at the end of the inquest on **2nd November 2017**. The conclusion of the inquest was that the medical cause of death was 1(a) hanging. The short form conclusion was "Suicide".
4	**CIRCUMSTANCES OF THE DEATH** 1) On the 26/6/2017 Anne hanged herself whilst she was alone inside the house of a friend in Merryfield Road, Eltham. She had secured the house from the inside and her friend, [redacted], had to gain access by a ladder to an upstairs room. She left a handwritten message expressing that her life had been "ruined" by financial debts caused by a former partner and apologising to her friend, [redacted] 2) The inquest heard evidence that on the 8th May 2017 Anne had become very distressed by a solicitors' letter claiming substantial legal fees, dating back to 2010, which had been unpaid by her ex-cohabiting and business partner. 3) On the 9/6/2017 after taking an overdose of paracetamol tablets she was visited by the Lewisham Home Treatment (psychiatric) Team (Oxleas HTT) on the 10/6/17 and was voluntarily admitted to hospital by the Oxleas NHS Foundation Trust (Oxleas). Oxleas covered the Eltham area. Anne's usual address was in Surbiton prior to her temporary stay in Eltham. 4) Due to a shortage of psychiatric beds she was placed by Oxleas in the Priory Hospital Ticehurst House in Sussex, which is a private hospital, and was discharged to her friends address in Eltham on the 23/6/17. 5) During the inquest I read the evidence of [redacted] a consultant Psychiatrist at the Priory Hospital, who recorded that prior to Anne's discharge from hospital she consented to staff speaking to her brother [redacted] and Peter Forrester who provided her accommodation in Eltham.

6) [redacted] candidly noted in his report that there was no record of any staff contacting Anne's friend or her brother prior to discharge.

7) On the 25/6/17 Anne was seen by the Oxleas HTT at the Eltham address. The Oxleas HTT did not have the benefit of a discharge plan from the Priory Hospital.

8) In a Root Cause Analysis report provided by Oxleas NHS Trust it was recorded that as *"AM approached her discharge from Ticehurst Priory, there is no evidence of forward discharge planning with the community team to whom care was being transferred or the address where AM would be staying and therefore which team would be responsible for her follow up".*

9) During the inquest both [redacted] and [redacted] indicated to me their concerns that they were not contacted by the mental health services prior to Anne's discharge from hospital to discuss her care in the community.

10) At the end of the inquest I indicated to the representative for Oxleas, [redacted] and [redacted] that I was considering making a regulation 28 report but before doing so I would be assisted by written representation from Oxleas concerning what had been done by Oxleas since the death to address the problems concerning discharge from hospital in the RCA report. I gave Oxleas 14 and days to respond and then a further 14 days for [redacted] and [redacted] to provide written observations on the Oxleas response.

11) The response from Oxleas, 13/11/17 (received 23/11/17), identified the following recommendations and progress:

i) GP records must be requested by the Greenwich Home Treatment Team when an unknown out of area patient is referred to the service.

ii) Clinical documentation must be updated and in a timely manner.

12) In responses I received from [redacted] they both expressed concerns that neither of them had been contacted by the Priory hospital staff prior to Anne's discharge and that Anne's indication that she was willing for staff to contact them both had not been communicated to the community HTT. In the case of [redacted] he expressed the opinion that if the mental health services had contacted him he would have been more aware of the risk Anne presented to herself and he might have been able to help avert the tragedy.

5 **CORONER'S CONCERNS**

From the evidence before me at the inquest and written representations I have received after the inquest there are 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 am concerned that the staff at the Priory Hospital did not make contact with friends and relatives after Anne had consented to them being contacted.

(2) The Priory Hospital did not formulate a written plan, before discharge from hospital, identifying the HTT who would be responsible for onward care in the community and, in particular making the relevant HTT aware that Anne was agreeable to health care professionals speaking to Peter Forester and Bernard Bakes regarding support with her mental health issues.

	(3) The Priory Hospital did not identify a responsible HTT for the discharge address in Eltham and there was no liaison with an HTT prior to discharge. (4) The Oxleas HTT do not appear to have proactively contacted the Priory Hospital for a written discharge plan prior to, or at the time, of the home visit on the 25/6/17. Had the HTT made contact with the Priory Hospital it would still have been possible to formulate a plan (including the availability of collateral assistance from Messrs [redacted]. (5) The Oxleas HTT do not appear to have been aware of Anne's willingness for mental health professionals to contact [redacted] regarding community support with her suicide risk. Had Oxleas HTT proactively made contact with the Priory Hospital they could have been made aware of this arrangement.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations have the power to take the following action: - 1. **The Priory Hospital** should indicate what steps have been taken since the death to ensure that where a patient has given consent to staff contact named friends and relatives in the community that efforts should be made to consult those individuals when preparing a discharge plan. 2. **The Priory Hospital** should indicate what steps have been taken since the death to ensure a system of promptly issuing care plans prior to discharge into the community including contact details of friends and next of kin where the patient consents to contact with named individuals. 3. **The Priory Hospital** should indicate what steps have been taken since the death to ensure that the responsible HTT for the area in which the patient will be living is contacted directly and that such contact is confirmed by a response from the relevant HTT. 4. **Oxleas HTT** should indicate what steps have been taken since the death to ensure a system of liaising with the discharging hospital in situations where they have not been provided with a discharge plan in order to obtain the same or to urgently formulate one with the discharging hospital.
7	**YOUR RESPONSE** You are both under a duty to respond to this report within 56 days of the date of this report, namely by **12th February 2018**. I, the coroner, may extend the period. Your responses 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 who may find it useful or of interest: • **Secretary of State for Health, Department of Health.** • **The Care Quality Commission.** 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	**18th December 2017** **Christopher Williams – Assistant Coroner**