Regulation 28: Prevention of Future Deaths report

Alan MacDONALD (died 29.08.17)

	THIS REPORT IS BEING SENT TO: **1. Mr Paul Flynn** **Chief Executive Officer** **Addcounsel** **28 Grosvenor Street** **Mayfair** **London W1K 4QR**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 31 August 2016, I commenced an investigation into the death of Alan MacDonald, aged 61 years. The investigation concluded at the end of the inquest on 13 February 2018. I made a determination of death by suicide, when Mr MacDonald hanged himself at home on Monday 28/ Tuesday 29 August 2017.
4	**CIRCUMSTANCES OF THE DEATH** Alan MacDonald was referred to Addcounsel by his private general practitioner, but was assessed by Addcounsel's clinical director as being too unwell for community care and so was re-referred to a consultant psychiatrist with admitting rights at the Nightingale Hospital.

	He was admitted the same day, on 9 August 2017. After two weeks in hospital, he was assessed as having improved significantly and was discharged on Wednesday, 23 August. However, after the bank holiday weekend, he was found hanging on Tuesday, 29 August.
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. Addcounsel's clinical director, a non medically qualified counsellor, continued to visit Mr MacDonald while Mr MacDonald was being treated as an inpatient at the Nightingale by a consultant psychiatrist. The clinical director told me that he was in a therapeutic type relationship, but he was not treating Mr MacDonald or giving him therapy. In addition to the psychiatrist consultations, therapy was available at the Nightingale. The daily Addcounsel visits inevitably entailed further cost to Mr MacDonald, as well as the additional cost of going through Addcounsel to the Nightingale in the first place, without giving treatment in return. I understand that this issue has been addressed by Addcounsel, following Mr MacDonald's death. I was told at inquest that in future, when Addcounsel recognises that a patient is too unwell to be treated in the community and requires admission, Addcounsel's file will be closed. In this way, a patient will not pay for visits at which no treatment is being offered. One of Mr MacDonald's worries, expressed at consultation with his psychiatrist when Addcounsel's clinical director was present, did centre on his financial situation. He was very anxious that his money was running out and he was not earning while he was in hospital. (After discharge from hospital, he told a friend that he had paid Addcounsel £20,000, and was not going to pursue follow up treatment.) Despite the fact that the Addcounsel clinical director knew of Mr MacDonald's money worries, he neither brought this to the attention of Addcounsel's relationship director, the person responsible for charging Mr MacDonald, to enable consideration to be given to reducing the charges, nor did he highlight to Mr McDonald the potential to access care via the NHS. This seems to be a potentially devastating omission, not simply on an individual basis but also in terms of Addcounsel's systems.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 23 April 2017. 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • Nightingale Hospital, London • [redacted], psychiatrist • [redacted] brother of Alan MacDonald • [redacted], friend of Alan MacDonald 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 21 February 2018