REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Rt. Hon. Sajid Javid, Secretary of State for Health and Social Care.
1	CORONER I am Chris Morris, Area Coroner for Greater Manchester (South).
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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST On 11th March 2020, Alison Mutch OBE, Senior Coroner for Greater Manchester (South), opened an inquest into the death of Dr Malcolm Dixon who died on 29th December 2019 at the Priory Hospital, Altrincham. The investigation concluded at the end of the inquest which I heard between 1st and 5th November 2021. The consultant pathologist who undertook the post mortem examination determined Dr Dixon died as a consequence of: [redacted] At the end of the inquest, I recorded a narrative conclusion that Dr Dixon took his own life whilst his state of mind was adversely affected by a severe depressive illness.

4	CIRCUMSTANCES OF THE DEATH During autumn of 2019, Dr Dixon became unwell with what was later diagnosed as a severe depressive illness. Dr Dixon was admitted to the Priory Hospital, Altrincham as an informal, voluntary patient and was treated by means of medication, observation by and interaction with staff, and participation in activities sessions. Dr Dixon died on 29th December 2019 at the hospital, as a consequence of [redacted] This was an impulsive act undertaken within the context of an episode of severe mental illness.
5	CORONER'S CONCERNS The MATTERS OF CONCERN are as follows. – 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 MATTER OF CONCERN is as follows. – The Court heard it was likely that an observation chart, designed to record regular observations, had been pre-populated by a staff member to show when observations were intended to be taken as opposed to recording when they actually took place. Additionally, the Court heard that the automatic timings generated by the electronic care record system in use at the Priory could be over-written manually, thus leading to inaccurate times being recorded in the records. The following concerns arise from the above: 1. Given the particular importance of documented observations being taken at specific intervals on mental health wards, it is a matter of concern that standardised observation charts (together with accompanying standard rules as to how they should be completed) are not in use across these settings both in the NHS and private sectors; 2. For similar reasons, it is a matter of concern that automatic time-stamps generated by electronic care records systems can be overwritten by users without the corresponding record showing clearly that this has happened, whilst also recording of the actual time an entry has been made. 3. It is a matter of concern that, where record keeping on a ward is undertaken by unregistered staff such as Nursing Assistants and Healthcare Assistants, such individuals are not subject to professional

	requirements in respect of documentation, such as those which exist for doctors and nurses.
6	ACTION SHOULD BE TAKEN In my opinion 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 20th January 2022. 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 Broudie Jackson Canter solicitors on behalf of Dr Dixon's family. I have also sent a copy to Browne Jacobson LLP on behalf of the Priory Group Ltd., and the Care Quality Commission, 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	Dated: 25th November 2021. Signature: Chris Morris HM Area Coroner, Manchester South.