Chief Executive Officer
Priory

Monday 24 April 2023

Mr Jake Taylor
Assistant Coroner
West London Coroner's Court
25 Bagley's Lane
Fulham
London, SW6 2QA

Private and Confidential

Dear Mr Taylor,

Ms Annabel Jean Findlay - Response to Regulation 28 Report

I write to you in response to the Regulation 28 Report dated Wednesday 1 March 2023. The report was issued following the Inquest touching the death of Ms Annabel Findlay. You have raised three matters of concern in respect of Ms Findlay's discharge from Priory Hospital Roehampton (**PHR**).

Please note that an internal learning review of Ms Findlay's care and treatment was commissioned after we were notified of Ms Findlay's death and recommendations for improvement were made as part of that review. The recommendations were to ensure robust hospital discharge arrangements were in place. An action plan was created to evidence implementation of the recommendations and to provide assurance of learning. We shared a copy of this action plan with your Coroners Officer, , on Thursday 9 March 2023 and I attach it as an appendix to this response. The Senior Management Team at PHR were satisfied prior to the Inquest that the necessary improvements had been made and were therefore particularly upset and disappointed to receive a Regulation 28 Report in respect of this matter.

Please find the below responses to the matters of concern that you have raised.

1. **Contacting next of kin / emergency contacts at the point of hospital discharge**

You have raised a concern that staff did not contact Ms Findlay's next of kin / emergency contact at the point of her discharge from hospital.

Whilst we understand the concern, we believe that in the circumstances appropriate steps were taken by the hospital. Ms Findlay was an informal patient and she was considered to be at low risk at the point of her discharge i.e. she had made plans for the future and she was prepared to engage with staff following her discharge. It is also important to note that Ms Findlay had mental capacity to make decisions and had withdrawn consent for staff to share information with her family. Ms Findlay had provided Priory with the contact details for a friend but had specifically asked that confidential information was not divulged.

However, in the interest of learning, the PHR Hospital Director, , has shared a reminder with hospital colleagues of the requirement to notify the next of kin or emergency contact of a patient, when self-discharge is taken against medical advice, where a patient consents to this information being shared. This was discussed during a Consultants' meeting held on Thursday 6 April 2023 and during a Clinical Governance meeting held on Thursday 20 April 2023.

2. Booking follow-up appointments

You have raised a concern that a follow-up outpatient appointment was not booked for Ms Findlay prior to her discharge from hospital.

This matter had already been identified as an improvement action as part of the internal learning review which took place before the inquest. The improvement action has been taken forward by the hospital management team and consequently, two reminders have been circulated to all relevant medical colleagues at PHR to ensure that any required outpatient follow-up appointments are booked prior to a patient's discharge. A third reminder will be shared during April 2023. We have continued our monthly audit of this arrangement and will continue to do so until we reach 100% compliance for three consecutive months. This requirement was also reiterated to staff during the Consultants meeting and Clinical Governance meeting referenced above.

3. Contacting patients following hospital discharge

You have raised a concern that Ms Findlay was not contacted until 10 days after she discharged herself from hospital

This matter was also identified as an improvement action as part of the internal learning review referenced above. Nursing and medical colleagues at the hospital have since been reminded about the requirement to make telephone contact with a patient 48 hours after discharge (unless the patient has a confirmed community mental health team/crisis recovery home treatment team appointment within 72 hours of discharge). The purpose of the telephone call is to check on the patient's welfare and respond to any issues identified. We have already audited the provision of post-discharge telephone calls and identified significant progress: we will continue to audit this monthly, until we have three successive months of 100% compliance.

I trust that the actions outlined above will provide the assurances you seek in respect of this matter.

Yours sincerely,

____

Chief Executive Officer
Priory