REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **PRIORY HOSPITAL, ROEHAMPTON**
1	**CORONER** I am Mr. Jake Taylor, assistant coroner, for the coroner area of Inner West London.
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 27 September 2021, I commenced an investigation into the death of Annabel Jean Findlay who died aged 56 years' old. The investigation concluded at the end of the inquest on 1 March 2023. The conclusion of the inquest was a short-form conclusion of suicide. The medical cause of death was determined to be fatal pressure to the neck.
4	**CIRCUMSTANCES OF THE DEATH** Ms. Findlay had a history of psychiatric illness and a long history of depression, for which she was receiving support and treatment. She was an outpatient under the care of psychiatrists at the Priory Hospital, Roehampton from 7 February 2018 until 20 August 2021. She was noted as not always engaging with medical professionals and disclosed that she had been self-medicating. On 20 August 2021, Ms. Findlay was admitted as an inpatient at the Priory Hospital, Roehampton, following a referral from her General Practitioner for "various complaints". Ms. Findlay had been taking the anti-depressant venlafaxine but this had resulted in unintended urinary retention and prior to her admission, her intake was being reduced by her treating psychiatrists. On 20 August 2021, following her admission, she was started on a different anti-depressant, vortioxetine and attended to by staff and medical professionals. On 27 August 2021, Ms. Findlay discharged herself from the Priory Hospital, Roehampton. This was despite the requests of her treating psychiatrist for her to remain so that her response to her change of medication could be monitored. At the time of discharge, no significant risks were identified and Ms. Findlay was deemed to have capacity and was deemed fit for discharge. A discharge plan was put in place. The discharge plan for Ms. Findlay included that she was to contact the hospital to make an outpatient appointment. She was also discharged with a week's supply of medication. A discharge summary was sent to her GP.
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 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. – Although a discharge plan was implemented in Ms. Findlay's case, it would appear that steps were not taken to contact her emergency contact and/or next of kin, such as to facilitate Ms. Findlay being supported in the community upon discharge. Ms. Findlay, having discharged herself, left the hospital with next of kin/ emergency contacts not being aware of her discharge – despite, her emergency contact being the person who had transported her to the Priory Hospital. No follow up appointment was made prior to Ms. Findlay's discharge and no attempts were made to contact her following her discharge until 6 September 2021. The matters of concern are as follows: A. That no contact was made with next of kin/ emergency contacts prior to, or at the time of her release. B. No follow up appointment was booked prior to Ms. Findlay's discharge. C. No attempt was made to contact Ms. Findlay until 6 September 2021 (some 10 days following her discharge).
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 26 April 2023. 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. I have also sent it to [redacted] – Ms. Findlay's emergency contact - 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	**1 March 2023** ***J. Taylor***