	REGULATION 28 REPORT TO PREVENT **FUTURE DEATHSTHIS REPORT IS BEING SENT** **TO:** 1. [redacted] **Chief Executive Officer of The Priory Group** 2. [redacted] **Chief Executive Officer if NHS England**
1	**CORONER** I am Caroline Topping assistant coroner, for the coroner area of Surrey.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** An inquest into the death of Miss Amy Henderson was opened on the 26th April 2022 and resumed with a jury on the 6th February 2023. The inquest was concluded on the 23rd February 2023. Evidence in respect of matters pertaining to this report was heard on the 20th March 2023. The jury concluded that Miss Henderson died on the 21st March 2022 at the Priory Hospital, Woking and the medical cause of her death was: 1a Suspension They concluded with a narrative conclusion and found that: 1. The Priory staff knew Amy had suicidal ideation, but they did not know any details concerning plans, or that she had practised tying a ligature. 2. No-one at the Priory asked her family about her suicide plans. 3. It is not possible to determine what Amy would have said to her consultant if she had been asked about suicide plans. Amy denied having any plans when asked by an HCA and she denied having thoughts of suicide in her 1:1 with a SHCA. 4. If Amy's mother had been asked, she would have shown the screen shots from Amy's phone and given details of Amy practising tying ligatures. Amy's mother has no recollection of volunteering the information. 5. Despite the notes from the therapy sessions being uploaded at 16.06, there was no formal request for Amy to be reviewed. There is evidence from professionals that Amy should have been reviewed urgently on the basis of the notes, if they had been scrutinised. 6. If information about Amy practising tying a ligature had been known, there would have been more consideration given [redacted] bearing in mind the balance of risk and least restrictive practice. [redacted]

	21st March. Amy was generally compliant with staff, [redacted]. 7. After the identification of the disabled toilet as a high-risk area in 2021, the ligature risk of the disabled toilet was not effectively managed although the Priory considered that it was. 8. Amy had unrestricted access to the disabled toilet, which was accessible to all patients, staff and visitors. 9. The Jury was not able to make a finding as to whether Amy was alive between 19.35 and 19.47. In summary the following facts, on the balance of probabilities, made a material contribution to Amy Henderson's death: a. Risk Assessments were not performed in line with Priory policy. b. There was no Key Worker present throughout Amy's stay. c. There were incomplete observations and little evidence of engagement with Amy during observations. Boxes were not ticked on Observation and Engagement Records. d. The family was not consulted or questioned about Amy's Suicide Plans. e. Therapy notes were not acted upon. f. There was a lack of staff training in Postnatal depression. g. There was a lack of continuity of care. h. The disabled toilet was not locked. i. Staff knowledge of the ligature footprint was inconsistent. Amy committed suicide. She used a [redacted] ligature and intended to kill herself. She is shown on CCTV entering the disabled toilet and no-one else entered it until Amy's body was discovered. The death was contributed to by Neglect
4	**CIRCUMSTANCES OF THE DEATH** Miss Henderson had a baby in 2021. When her baby was 11 months old she returned to work, but was signed off sick suffering from anxiety and depression. On the evening of the 14th March 2022 she was taken by her family to Kingston Hospital and assessed by the liaison psychiatric team. She expressed suicidal thoughts and plans [redacted] She was diagnosed with post partum depression. She was advised to become an informal patient in the NHS but there was no bed available so she would have had to wait in the hospital until a bed could be found. She decided to seek a private admission the following day. On the 15th March 2022 she sought treatment at the Priory Hospital, Woking. She had a preadmission assessment with [redacted] a consultant psychiatrist who accepted her as a patient. She told him that she had a suicide plan but did not provide details of what it was. He assessed her as a high risk of suicide and set observations at four times an hour. She was allocated a Key Worker who was not due to be in the hospital until 22nd March 2022, and a Co-worker, who had a one-to-one with her on 19th March 2022. Her overall mental health appeared to have improved when she was reviewed by [redacted] on March 18th 2022. The observation level was reduced to twice an hour on the 16th March 2022, and then further to

	once an hour on the morning of March 21st 2022, on each occasion without a risk assessment being performed as specified in the Priory policy. Later on the morning of the 21st March 2022 Miss Henderson made comments during a therapy session which indicated that her mental health was deteriorating. The therapists recorded what she had said in her notes, but the concerns were not considered to be serious enough to be escalated to the nursing team. Evidence presented to the inquest suggests that Amy's observations should have been increased at this stage. Amy was not reviewed by the nursing team when the therapists' notes were uploaded onto the system at 16.06 on 21st March 2022. The information was not reviewed and therefore not acted upon. Miss Henderson was last seen in person at 18.02 in the dining room. At 18.12. she entered the downstairs disabled toilet. The disabled toilet had been identified in risk assessments as a high-risk area but it was not locked. She wrote a farewell note to her parents at 18.14. She was found in the disabled toilet on the ground floor at 20.01. She had taken her own life by suspension, [redacted]
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. Inmy 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. The information that Miss Henderson had practised tying a ligature was divulged by her at Kingston Hospital but not repeated on admission to the Priory Woking. The evidence given at the inquest was that there is no quick method to obtain NHS records on admission to a private hospital. A request could have been made but the records would have taken over a week to be released. The records were not sought. An ability to obtain the NHS records quickly would have been of assistance to the Priory clinicians. 2. The Priory Woking has a policy in relation to the removal of banned and restricted items but there was a lack of clarity and confusion among the clinicians as to who was responsible for ensuring that such items are identified and removed from the patient at admission.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you[AND/OR 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 16th June 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 and to the following Interested Persons: Miss Henderson's family The Priory Woking [redacted] The Care Quality Commission I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find ituseful or of interest. 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 usefulor of interest. You may make representations to me, the coroner, at the time of your response, aboutthe release or the publication of your response.
9	**Caroline Topping, 21st April 2023**