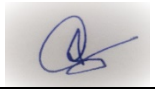
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Steve Barclay, Secretary of State for Health and Social Care, Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU. 2. [redacted], Chief Executive, NHS England, PO Box 16738, Redditch B97 9PT
1	**CORONER** I am Andrew Bridgman, Assistant Coroner, for the coroner area of South Manchester
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 01.03.22 an investigation commenced into the death of Lauren Elizabeth Bridges who died on 26.02.22, aged 20 years. The inquest concluded on 01.09.23. **The medical cause of death was** 1a) Hypoxic brain injury 1b) Cardiac arrest 1c) Hanging injury **The conclusion of the jury was** *Lauren Elizabeth Bridges ended her life by ligature. This was misadventure with Lauren not intending to commit suicide.* *Missed opportunities for moving Lauren closer to home with acute and PICU beds available during significant periods between July 2021 and February 2022 at St. Ann's, Seaview and Haven wards, contributed to increased incidents and her death.* *The prolonged stay in a PICU placement in Priory Cheadle led to iatrogenic deterioration. This was prolonged by a delayed discharge. There was inadequate communication about Lauren from Dorset Healthcare NHS Trust to relevant parties, and there was insufficient communication about Lauren from Priory Cheadle to relevant parties.* *Dorset Healthcare NHS Trust did not recognise the exceptional circumstances of the effects on Lauren being in an out-of-area placement over 260 miles away from home.*
4	**CIRCUMSTANCES OF THE DEATH** Lauren lived in Bournemouth. From March 2020 Lauren had been an in-patient, detained under section 3 of the Mental Health Act 1983. In January 21 Lauren was admitted to a Rehabilitation Unit, at The Priory, Dorking, as an Out-of Area patient. This placement was commissioned by Dorset CCG (as it was then – now Dorset ICB). Dorking is just over 100 miles from Bournemouth. In about mid-June 2021 Lauren's mental health deteriorated and it was determined on 01.07.21 that Lauren needed to be transferred to a Psychiatric Intensive Care Unit to keep her safe. On 23.07.21 Lauren was transferred to Pankhurst Ward PICU, The

	Priory, Cheadle. Again, Lauren was an Out-of-Area patient at a distance, now, of some 260 miles from home. This placement was commissioned by Dorset Healthcare NHS Trust. Lauren was ready for step-down from the PICU by 02.09.21. The plan being to seek an acute bed, at or closer to home, while a suitable Rehabilitation Unit was found. Lauren remained in the PICU, at The Priory, Cheadle for the next 5 months, until her death on 26.02.22 following a ligaturing incident on 24.02.22. Over that time Lauren's mental health deteriorated, with an increasing number of incidents of self-harm. A major factor in Lauren's deterioration was the distance from her home and family.
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. – Matter One This is the second inquest I have heard where the delayed discharge/repatriation of an Out-of-Area patient from an independent provider's hospital has been a contributory factor in that patient's death. Lauren was 20 years of age. The other inquest involved a 15 years old patient - 115 miles from home. Both of these cases illustrate, a) Underfunding for local mental health beds. b) An over-reliance by the NHS on independent providers for mental health beds. The Government set itself a target to eliminate inappropriate (which I infer would include delayed discharge) Out-of-Area in-patient placements in mental health services for adults by 2020-21. Matter Two The jury identified inadequate and insufficient communication between Dorset Healthcare NHS Trust, The Priory and relevant parties. I heard evidence that Dorset Healthcare NHS Trust have appointed a designated Care Co-ordinator for its Out-of-Area patients. Having a single point of contact will alleviate some of the communication issues identified. I heard evidence from The Priory as to some of the challenges it faces when dealing with the NHS commissioning bodies, be they Hospital Trusts or Integrated Care Boards. The Priory is just one of the several independent providers of mental health care. 1. The Priory deals with 42 NHS separate commissioning bodies. 2. There are multiple software programmes for record keeping for these organisations, which makes transfer and sharing of clinical information cumbersome and difficult, as direct sharing is not possible. 3. These bodies have varying processes and requests for communication. 4. There is no national standard process for referrals into the independent sector nor for discharge/repatriation to the 'home team'. With regard to delayed discharge/repatriation of an Out-of-Area patient I heard evidence that The Priory have devised a protocol/standing operating procedure in respect of delayed discharge, which should reduce the risks of a patient being left miles from home at all and in any event reduce the time taken to repatriate. However, it relies on the 'home team's' engagement in the process. In brief, the protocol is as follows, 1. Once it has been determined that a patient is ready for discharge/step-down/repatriation BUT no bed/placement is available that is a delayed discharge and the protocol is triggered. 2. In week one The Priory MDT hold a professionals meeting to explore reasons for

	delay and together with the 'home team' identify SMART actions. 3. If after 4 weeks there is limited progress The Priory MDT will request the 'home team' ICB to arrange a Care & Treatment Review. 4. If there is, by then, no or little progress there should be discussions between the Priory Head of NHS Partnerships and the 'home team' Commissioning Managers. 5. As a last resort: service of notice on the patient's placement. The protocol is heavily reliant on engagement from, and cooperation of, the numerous NHS commissioning bodies. The protocol requires a low threshold for the escalation of delays to the appropriate manager and/or commissioner at the 'home service'. There are over 60 independent providers for in-patient mental health services. The initiative taken by The Priory is to be applauded but it is just one of many independent providers for some 42 separate NHS commissioning bodies. There is a clear danger that it will not be adopted by the other independent providers, indeed there is no reason for them to be aware of its existence. In the premises, Out-of-Area delayed discharge, and its detrimental effect on a patient's mental health, will remain a matter of concern. While there remains a shortage of local NHS mental beds and the Government remains committed to eliminating inappropriate Out-of-Area in-patient placements the development of protocols or standardised operating procedures to avoid delayed discharge, or limit the length of delay, is a clearly a matter for the NHS rather than the individual independent providers.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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. 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 namely, who may find it useful or of interest. 1. Lauren's family 2. The Priory 3. Dorset Healthcare NHS Trust 4. Dorset ICB 5. Bournemouth, Christchurch & Poole Council 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 this 19th day of September 2023** 

	Andrew Bridgman **HM Assistant Coroner**