REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted], Chief Executive Officer, Priory Head Office, Floor 5, 80 Hammersmith Road, London W14 8UD 2. [redacted], Chief Executive, NHS Greater Manchester Integrated Care Board 3. Chief Executive Pennine Care NHS Foundation Trust
	CORONER I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 25th April 2024 I commenced an investigation into the death of Mr David Thompson who died on the 3rd March 2024. The investigation concluded on the 31st July 2024. The medical cause of death was confirmed as 1a) Hypovovalmic Shock 1b) Deep cuts to left wrist 2) Fatty liver disease (alcohol related), Affective disorder, Acute alcohol intoxication. A narrative conclusion was recorded; "On a background of a longstanding diagnosis of Affective disorder of which emotional dysregulation was a feature, the deceased died as a result of self-inflicted stab wounds. His diagnosis together with acute alcohol intoxication suggested on the balance of probabilities that his actions were impulsive and he did not intend to end his life."
4	**CIRCUMSTANCES OF DEATH** Mr Thompson had a longstanding diagnosis of bi-polar disorder. Over the years he had also used alcohol and illicit drugs, albeit at the time of his death he had not used drugs for years and had been abstinent from alcohol for several years. He was under the care of Pennine Care NHS Foundation Trust for his mental health. In June 2023 David had self-harmed by cutting himself and had been admitted to Tameside hospital where he remained as an inpatient until 29th August 2023. He also underwent Transcranial Magnetic Stimulation therapy at Royal Oldham hospital until the 23rd September 2023. At the time David had health insurance via his employment so he took the opportunity to undergo further inpatient treatment at the Priory hospital in Altrincham. He was admitted under the care of [redacted] on the 23rd September 2023. He remained an inpatient until the 19th October 2023. On his discharge Mr Thompson relapsed and was then admitted to the Priory Hospital in Dorking from the 28th October until the 8th November 2023. This was as an NHS patient and the location was due to bed availability. Throughout this time Mr Thompson remained under the care of his NHS Psychiatrist [redacted] who reviewed him as an outpatient in December 2023. At this time Mr Thompson was stable and a plan was to review him in March 2024. In January 2024 he was reviewed by [redacted]. This was the outpatient appointment which had been made following his discharge on the 19th October. It is acknowledged that Mr Thompson was stable

	at this appointment. The plan following this appointment included: "*to continue to get input from the local NHS Mental health services.*" On the 29th February 2024 Mr Thompson was in Budapest accessing dental treatment when he was advised he may require a biopsy due to a possible abnormality on his gums. He returned home on the 2nd March 2024. He had intimated some level of distress at this news. It is also likely that he relapsed and used alcohol. On his return home he did not wish relatives to stay with him. He then consumed alcohol and cut his wrists. He had attempted to make contact with some family in the middle of the night but due to the time of day his messages were not accessed until the morning.
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. It is acknowledged that in the case of Mr Thompson there was no evidence any of these concerns caused or contributed to his death. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows:- **For the Priory - DORKING** 1. The Incident Review of his admission to the Priory Dorking indicated that there was no My Safety Plan commenced on admission or complete prior to his discharge. 2. There was no engagement prior to discharge with the local Home Based Treatment Team. 3. There was no consultation with the Consultants who had treated Mr Thompson at the Priory in Altrincham only a few weeks earlier. 4. There was no 48 hour follow up call to Mr Thompson following his discharge, as per Priory Policy. 5. A discharge clinical entry and discharge risk assessment was not completed and there was no evidence of crisis information having been provided. 6. There was no evidence that the four standard care plans had been opened during Mr Thompsons inpatient stay. 7. When conducting the internal review no members of the nursing staff were spoken to to consider why the matters highlighted above had not been carried out. There was therefore a lack of understanding as to whether this was an individual failing or error or a cultural / system failure. Nor was consideration given to whether any individuals should be reported to their regulatory body. **For the Priory - ALTRINCHAM** 1. On the outpatient appointment in January 2024 the fact that Mr Thompson had been an inpatient in the Priory in Dorking following his discharge from the Priory Altrincham was not known. There was a lack of awareness as to how to access certain parts of the medical records which would have shown this information. Mr Thompson did not volunteer this information so there was no discussion with him as to why he had relapsed so quickly. 2. At the time of his appointment in January 2024 Mr Thompson was not under any NHS community services such as the home based treatment team. This was not recognised or known when formulating his ongoing plan. 3. No internal review was undertaken of Mr Thompsons admission within the Priory Altrincham to consider whether there was any learning **For All:** 1. There was a complete absence of any Consultant – Consultant discussions or communication, given this patient was receiving care from both the NHS and privately.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **08th October 2024**. 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 namely:- Family of Mr Thompson 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 from. 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	Date: **12 August 2024** Signed: