Mr Christopher Long
Area Coroner
Lancashire and Blackburn with Darwen

Via email: Coroner's Officer [redacted]

14 January 2025

Private and Confidential

Dear Mr Long

Mr Kevin Ince - Response to Regulation 28 report

I write to you in response to the Regulation 28 report dated 18 November 2024. The report was issued following the Inquest touching the death of Mr Kevin Ince, which was heard on 15 November 2024. The inquest concluded that Mr Ince died from natural causes.

In the Regulation 28 report you raised two areas of concern for Priory to consider:

1. *The inquest heard clear evidence of regular refusals of necessary and appropriate medical treatment by patients detained under the Mental Health Act 1983, over several years with insufficient consideration of steps that were then appropriate including a lack of steps to persuade the patient, insufficient consideration of the powers under the Mental Capacity Act 2005 and insufficient consideration of utilising s.63 of the Mental Health Act 1983.*

2. *Insufficient action was taken when patient detained under the Mental Health Act 1983 routinely declined food over a prolonged period.*

Priory response to matter of concern 1

Following Mr Ince's death, a 'Management of Declined Physical Health Monitoring" flowchart was introduced at Kemple View. I understand the mechanics of this were explained by the Hospital Director during the inquest. This flowchart sets out the process to follow when a patient declines physical health checks, to include escalation to the Responsible Clinician and Primary Nurse for discussion at the next multi-disciplinary team (MDT) meeting. The patient's capacity to decline physical health checks is to be assessed and where the patient is deemed to be without capacity, a best interest meeting is to be arranged. All decision making is to be documented.

In response to feedback received during the inquest and following reflection and wider discussion, this flowchart has now been revised with input from Priory's Head of Mental Health Act and Mental Capacity Act Operations. The flowchart now also includes consideration being given to the involvement of a patient's family in discussions (where patient consent allows) and to ensure powers under section 63 of the Mental Health Act 1983 are also taken into account when considering a patient's best interests if they decline physical health monitoring.

The revised flowchart was presented at the Physical Healthcare Committee meeting, which is chaired by Priory's Chief Medical Officer on 10th January 2025 for discussion and will be added to Priory policy "H100 Monitoring Physical Health of Inpatients" and cross referenced within relevant Mental Health Act or Mental Capacity Act policies, for use across all Priory Healthcare services. It is proposed that consideration be given to implementing a focused e-learning training module to support colleagues to understand the interface between the Mental Health

Act and Mental Capacity Act decisions and the process to be followed by Priory colleagues when physical health checks are declined.

A database has also been created at Kemple View to improve the recording of data about patients who have refused physical health monitoring using a clear RAG (Red, Amber, Green) rating system. This database is now reviewed weekly during the enhanced handover meeting, with actions documented where non-compliance is observed in accordance with the flowchart.

Discussions have also been ongoing with Priory's IT department to explore how the above monitoring could be captured within CareNotes (Priory's electronic patient records system). Electronic monitoring of physical health observation checks and refusals by patients will be incorporated within CareNotes in January 2025 and a dashboard to enable monitoring of this will be built into CareNotes from February 2025.

Priory response to matter of concern 2

Following Mr Ince's death, a 'Management of Poor Diet and Fluid Intake" flowchart was also introduced at Kemple View. I understand this was also explained by the Hospital Director during the inquest. This flowchart shows the process to follow when a patient has inadequate diet and fluid intake, to include escalation to the Responsible Clinician for discussion and referral to the Dietician for advice. The patient's capacity to refuse an adequate nutritional diet is to be assessed and where the patient is deemed to be without capacity, a best interest meeting is to be arranged. All decision making is to be documented.

This flowchart has also been reviewed by Priory's Head of Mental Health Act and Mental Capacity Act Operations and also includes consideration being given to the involvement of a patient's family in discussions (where patient consent allows) and to ensure powers under section 63 of the Mental Health Act 1983 are taken into account.

A database has also been created at Kemple View to capture data about patients who are monitored using food and fluid intake charts: this will facilitate a more thorough review as to whether adequate nutrition is being accepted by the patient. This database is now reviewed weekly during an extended hospital handover meeting, with actions documented in accordance with the flowchart where a nutritional diet is refused.

A Priory dietician is scheduled to complete a briefing to Priory Hospital Kemple View staff in January 2025 on the topic of good nutrition and fluid intake.

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

Yours sincerely,

[redacted]

[redacted]
Chief Executive Officer
Priory