PRIORY

GROUP OF COMPANIES

[redacted]
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Friday 2 February 2018

Case Ref: 01820/2017

Mr John Thompson
Assistant Coroner, London Inner South
Southwark Coroners Court
1 Tennis Street
London, SE1 1YD

Private and confidential

Dear Mr Thompson

Re. Anne Morris (deceased)

I write to you in response to the Regulation 28 Report to Prevent Future Deaths dated Friday 22 December 2017 that you issued in response to the Inquest Touching the Death of Ms Anne Morris.

I note that you have addressed your report to [redacted] and [redacted]. Please note that [redacted] is no longer connected with Priory Hospital Ticehurst. I write to you on behalf of [redacted]

Firstly I would like to advise you that we were disappointed that this particular Inquest went ahead without our full involvement. Had we been invited to give evidence we would have reassured you in terms of the improvement actions taken in response to Ms Morris' death. Despite our reservations we accept your report and set out the matters of concern and our responses below.

The staff at the Priory Hospital did not make contact with friends and relatives after Ms Morris had consented to them being contacted.

Please note that we have reviewed and re-launched Priory Healthcare Policy H02: Admission, Transfer and Discharge and made reference to the involvement of family, friends and carers in the discharge planning process (paragraph 5.1e). A rolling programme of training webinars which detail policy and practice is planned for 2018 and discharge planning will feature as part of these webinars. Please be assured that the point that you have made in respect of communicating with family and friends prior to discharge will be highlighted as part of these webinars.

The Priory Hospital did not formulate a written plan, before discharge from hospital, identifying the Home Treatment Team (HTT) who would be responsible for onward care in the community and, in particular making the relevant HTT aware that Ms Morris was agreeable to healthcare professionals speaking to Peter Forester and Bernard Blakes regarding support with her mental issues.

As above this matter has been addressed as part of the policy review. Form H11A Discharge Checklist which is associated with the policy has been amended to include a section to record the contact details of friends and family (including the next of kin). The policy itself stipulates very clearly that care plans should be circulated prior to the patient's discharge from hospital. This point of good practice will be highlighted as part of the webinar training programme.

The Priory Hospital did not identify a responsible HTT for the discharge address in Eltham and there was no liaison with an HTT prior to discharge.

This matter has been addressed as part of the policy review. The newly reviewed policy reinforces the requirement to identify which service will provide care and support to the patient at the point of discharge from hospital (paragraphs 5.1b, 6.7 and Form H11A) and to ensure that the service confirm in writing their acceptance of their responsibility to deliver follow-up care and support. Once again this requirement will be highlighted as part of the webinar training programme.

We note that the fourth and fifth matters of concern relate to Oxleas Mental Health NHS Trust rather than to Priory Group.

I do hope that these actions will provide you with the reassurance that you require. If I can be of further assistance then please do not hesitate to contact me.

Yours sincerely,

[redacted]

Director of Risk and safety