REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Mr Trevor Torrington, Chief Executive Officer, The Priory Group.

CORONER

I am Chris Morris, Area Coroner for Greater Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 5th June 2019, I opened an inquest into the death of Wayne Lee Millett, who died at The Priory Hospital, Cheadle on 13th February 2019, aged 46 years. The investigation concluded at the end of the inquest, which was heard from 3rd to 10th February 2020, before a jury.

A post mortem examination determined Mr Millett died as a consequence of:

1)a) Acute Lung injury

b) Aspiration

c) Pseudo-obstruction of Small bowel most likely due to Clozapine Toxicity.

The jury concluded Mr Millett's death was drug-related, on the basis that complications of therapeutic use of the prescribed medication Clozapine set in motion a chain of events leading to his death.

CIRCUMSTANCES OF THE DEATH

Mr Millett had a long history of mental health problems and was a detained patient at The Priory Hospital, Cheadle pursuant to a s37 Mental Health Act 1983 hospital order made by the court.

Mr Millett had been diagnosed with paranoid schizophrenia, which proved refractory to treatment. As such, in conjunction with support and non-medical therapies, the mainstay of Mr Millett's treatment was the anti-psychotic medication Clozapine. The court heard evidence that Clozapine is reserved for treatment-resistant schizophrenia in the main, as a result of the nature and extent of side effects which can be associated with its use. In Mr Millett's case, the administration of Clozapine was endorsed by an independent second-opinion doctor.

Amongst other things, Clozapine has been associated with a range of gastro-intestinal side effects, ranging from constipation through to more serious problems leading to paralysis of the gut, bowel obstruction, and necrosis of part of the bowel.

In 2015 having become acutely unwell, Mr Millett was admitted to an NHS hospital where he was diagnosed with a paralytic ileus / pseudo-obstruction which was thought may have resulted from Clozapine use. As a consequence of this, upon his return to the Priory, a care plan was developed to seek to promote bowel motility, facilitate early identification of serious gastro-intestinal side effects of Clozapine, and to enable Mr Millett to receive prompt emergency treatment if clinical suspicion of bowel obstruction arose ("the Care Plan").

Whilst Mr Millett often complained of abdominal symptoms, there was an escalation in these from 11th February 2019. Notwithstanding this, the Care Plan was not followed, and Mr Millett became increasingly unwell leading to his collapse and death on 13th February 2019.

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. –

1) The Priory's own investigation into the circumstances of Mr Millett's death was notably lacking in meaningful critical analysis of the care and treatment he received, and in particular was fundamentally flawed in that it failed to consider the care given as against the Care Plan despite its obvious central relevance to his death.
2) The above concern, when taken in conjunction with the facts that:

   a) the evidence before the court confirmed the organisation's Director of Risk Management, [redacted] had input into the investigation; and
   b) the Peripatetic Director of Clinical Services who gave evidence before the court was unable to describe any overarching quality assurance process operating within the organisation in respect of serious incident investigations;

   This raises significant concerns as to the Priory Group's ability to learn from serious clinical incidents and to take action accordingly, thus creating a risk of future deaths.

3) The court heard differing evidence from staff working at The Priory Hospital, Cheadle and from the Peripatetic Director of Clinical Services as to what the organisation's expectations were in respect of care plans, and specifically the degree of adherence which were required to them. In the light of this significant divergence of opinion, it is a matter of concern that the Priory Group has not undertaken any audit of compliance with care plans (either at The Priory Hospital, Cheadle or more generally within the organisation) as a result of Mr Millett's death.

4) It is a matter of concern that, notwithstanding the cause of death identified on Post Mortem Examination and despite nearly a year having passed since Mr Millett's death, the organisation has yet to formally review the care plans of all patients prescribed Clozapine, with a view to ensuring each relevant patient has in place a clear plan for monitoring of

potential side-effects of the medication, which gives clear and authoritative direction to staff as to how to act if serious complications are suspected. It is a particular matter of concern that this step has not been taken, given the evidence heard from the Peripatetic Director of Clinical Services which suggested this would be a straightforward measure to accomplish, and one which could be completed within 28 days.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th April 2020. 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to Mr Millett's brother, [redacted] I have also sent a copy of my report to [redacted] of [redacted], who represented the Priory Group at the inquest.

I have also sent it to the Care Quality Commission, the Regional Medical Examiner for North West England, and Salford CCG (as commissioners of Mr Millett's care)

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.

Dated: 18th February 2020

Signature:

Chris Morris HM Area Coroner, Manchester South.