North East Kent Coroners
Cantium House
County Hall
Sandling Road
Maidstone
Kent
ME14 1XD

Telephone

New and Current Cases: 03000 410502

General Enquiries: 03000 410503

Email: kentandmedwaycoroners@kent.gov.uk

Date: 27 October 2020

Case: 333890

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Priory Group
CORONER

1 I am Joanne Andrews Area Coroner for North East Kent

CORONER'S LEGAL POWERS

2 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 9 March 2020 I commenced an investigation into the death of Martin Thomas BARRETT. The investigation concluded at the end of the inquest . The conclusion of the inquest was that Mr Barrett had taken his own life on 25 February 2020 and as such I gave a conclusion of suicide

3 The medical cause of death after post mortem was

1a Suspension by the Neck

1b

1c

II

CIRCUMSTANCES OF THE DEATH

Mr Martin Thomas Barrett took part in a telephone consultation assessment with the Priory Group by a Cognitive Behavioural Therapist for anxiety at 8am on the morning of his death. During that assessment, he stated that he had thought about suicide and planned how this may occur but did not indicate any immediate intent. The Therapist informed the Court that she considered that he was high risk of suicide but that he had engaged with her safety planning and had agreed to take steps to
4 keep himself safe. The Therapist therefore made an internal referral for a same day appointment with a Consultant Psychiatrist at the Priory Group for further assessment. This referral was made after the appointment and considered by the Consultant after his morning clinic which was around lunchtime. The Psychiatrist declined the referral as he considered that the needs of Mr Barrett were too complex and would be better resolved within the NHS. This decision was not communicated to Mr Barrett. Sadly he was found hanging at his home address around 3pm that day.

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. –

During oral evidence, I was advised that when an onwards internal referral is made to another clinician within the Priory Group which is then declined this is not communicated directly to the patient if the
5 treatment is funded by way of insurance cover. In those cases a notification would be provided to the insurers or the policyholder and then the Priory Group would not have any further contact with the patient. As such, patients that are considered to be higher risk by the clinician at initial assessment may not therefore have the opportunity to imminently consider alternative sources of treatment or receive any advice as to safety netting in the interim as this information is not being provided by clinicians to the patient. From the evidence that I heard it would be reliant on their insurers or corporate policy holders (who may well not be clinicians) to make contact with the patients to inform them of this during which time their health may have further declined or their risk increased.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe the Priory Group has 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,
7 namely by 26 December 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 the following Interested Persons [redacted]

8 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.

27 October 2020

9 Signature 

Joanne Andrews Area Coroner for North East Kent