REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. **The Chief Executive, The Priory Hospital, Cheadle**
2. **The Chief Executive, The Leicestershire Partnership NHS Trust**

CORONER

I am Robert Chapman, Assistant Coroner, for the Coroner Area of Rutland and North Leicestershire

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.

INVESTIGATION and INQUEST

On 28 July 2014 I commenced an investigation into the death of Anthony John Preston. The investigation concluded at the end of the Inquest on 27th July 2016. The conclusion of the inquest was:

The Cause of death was:

1.a. Hanging

The Conclusion of the Coroner was:

Mr Preston killed himself

CIRCUMSTANCES OF THE DEATH

Mr Preston had been suffering from mental health problems for a short period in the summer and autumn of 2013. On the 17 October 2013 he was admitted to The Priory Hospital in Cheadle, and remained there as a voluntary patient until the 11 November 2013. He was under the care of [redacted]. In early November he was granted home leave for a few days. The leave was not successful and he returned early to the hospital. It was clear that home leave was a time of great stress to Mr Preston.

On the 11th November he was discharged to his home, and into the care of the Crisis Team in his home area of Leicestershire. [redacted] gave evidence at the Inquest that the system upon discharge was for a nurse at the Priory to speak to a nurse in the Crisis team in Leicestershire, to send a fax to the GP indicating discharge and the medication prescribed, and it was to be followed up with a discharge letter.
There was no documentary proof of either the telephone call to the Crisis team, of any fax, and the only document available was a discharge letter to the GP that was sent on the 27 November, two weeks after discharge. The Crisis team denied that they had received any notification, telephonic or otherwise, of Mr Preston's discharge.

In consequence:

1. The Leicestershire Crisis Team were unaware of his discharge
2. Therefore, they did not arrange any follow up by the Crisis Team
3. After a few days at home Mr Preston became extremely anxious and depressed and [redacted] had to contact a mental health professional to request that he see Mr Preston, which he did immediately, and arranged a Mental Health Assessment.
4. This resulted in Mr Preston being admitted to The Bradgate Unit in Leicester on the 15th November, 4 days after leaving The Priory.

In May 2014 Mr Preston hanged himself. It is not suggested that there is any causal connection between his death and the discharge arrangements from The Priory.

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) Mr Preston had demonstrated, in his early return from home leave in the first few days of November, that living at home was a source of substantial stress, and likely to cause him severe anxiety and deepen his depression.
(2) The system for discharge of patients, whereby a nurse makes contact with (in this case) the Leicestershire Crisis Team does not appear to have been robust. There was no documentary proof of the telephone call.
(3) There was no immediate follow up by e mail or fax to the Crisis Team to notify the discharge, and the fact that Mr Preston was at high risk because of the anxiety created when he was living at home.
(4) As a result, Mr Preston and his main carer [redacted] were left without support at a time when he was at high risk.

ACTION SHOULD BE TAKEN:

The Priory hospital and the Leicestershire Partnership NHS Trust should review the discharge procedures. It would be appropriate to have a system in place to ensure that there is documentary proof of any telephone call, and importantly, written notice by way of e mail or fax of notification of discharge that is sent immediately upon, or prior to, the patients discharge. This will enable consideration of the appropriate arrangements to be put in place for the follow up.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 30th September 2016. 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] and her solicitors
Weightmans, solicitors to The Leicestershire Partnership NHS Trust

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.

11th August 2016 **Robert Chapman** **[SIGNED BY CORONER]**