Derek Winter
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr John Lawlor** **Chief Executive** **Northumberland, Tyne and Wear NHS Foundation Trust** **St Nicholas Hospital** **Gosforth** **Newcastle** **NE3 3XT**
1	**CORONER** I am Derek Winter, Senior Coroner for the City of Sunderland
2	**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
3	**INVESTIGATION and INQUEST** On 15/08/2014 I commenced an investigation into the death of Paige Louise Bell, aged 20, who died on 14/08/2014 at Sunderland Royal Hospital. The investigation concluded at the end of the Inquest on 26/02/2015. The conclusion of the Inquest was Misadventure, the cause of death being: - Ia Hypoxic Brain Injury; due to Ib Pressure on the Neck; due to Ic Hanging
4	**CIRCUMSTANCES OF THE DEATH** Paige Louise Bell was admitted to Sunderland Royal Hospital on 06/08/2014 after being found hanging in room at East Willows ward Cherry Knowle Hospital Sunderland. The Jury found that "As a result of an Emotional Unstable Personality Disorder Borderline owing to chronic self harm and parasuicidal tendencies, Paige Louise Bell attempted an act of self harm by applying a ligature to her neck resulting in her death. A contributing factor to this was contradictions within the observation policy creating ambiguity in its application."
5	**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. – Although a new Engagement and Observation Policy is to be implemented in April 2015 it may be that you would wish to review matters arising from the Inquest to enhance this further (if appropriate) so that there are no contradictions that may create ambiguity in its application. I appreciate that a lot of work has gone into the new policy. However, I note the following (and this

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	is not an exhaustive list): - • The new Observation record does not allow sufficient space for commentary. • The front sheet does not appear to have the RIO reference. • On the face of the document it is not clear that staff must complete all parts of the record. • If the rationale for observations were to change then the form needs to provide for that. • It may be possible in the fullness of time for the record to be completed electronically (perhaps with a tablet) with a drop down box and a freehand note facility? This would also allow for mandatory completion of certain parts of a form. • If electronic, the engagement/observation record could be readily accessible possibly via hyperlink. The same could be done for incident report forms rather than being manually filed. No doubt there will be full training undertaken with regard to the new Policy. I was concerned that not all relevant information was readily available and although I appreciate events can be fast moving it can then become even more important for staff to have access to up to date and accurate information from the notes. All staff need time to be able to complete such records in a more timely way. That takes me to my final concern and that relates to the difficulty with navigation around the records. Whilst this may be easier via a screen it was extremely difficult (even with time to do it) to be able to have a clear chronology of events and to understand the rationale for decisions. That has the potential to compromise patient management and safety. I also enclose a copy of my report to the Secretary of State.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Thursday 30th April 2015. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: - • Secretary of State for Health • [redacted] Clinical Risk Manager, Northumberland, Tyne and Wear Foundation Trust • City Hospitals Sunderland NHS Foundation Trust • Family and their Solicitors and Counsel • Care Quality Commission 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.
9	Dated this 3rd day of March 2015 Signature [redacted] Senior Coroner for the City of Sunderland