

Derek Winter Senior Coroner for the City of Sunderland

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Rt Hon Jeremy Hunt Secretary of State for Health Department of Health Richmond House 79 Whitehall London SW1A 2NS

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/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: -

- la 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. -

The case notes were not held in one place and not all transferred with the patient. I wondered if there were any ongoing plans to allow medical personnel to have immediate access to all notes electronically rather than notes following the patient as they will contain essential information for a patient's healthcare and treatment.

The Trust concerned is due to implement a new Engagement and Observation Policy. I should

be grateful to learn of any plans for a National policy/template to ensure consistency between Trusts. Also are there any plans to update guidance on the treatment and management of patients with Borderline Personality Disorder? I was directed to a NICE publication from January 2009. I enclose a copy of my report to the Trust concerned. 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. COPIES and PUBLICATION 8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: -Northumberland, Tyne & Wear Foundation Trust and their Solicitors and Counsel Clinical Risk Manager, Northumberland, Tyne & 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. Dated this 3rd day of March 2015 9 Signature Senior Coroner for the City of Sunderland