REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. The Chief Executive, Surrey and Sussex Healthcare NHS Trust** **2. The Chief Executive, Surrey and Borders Partnership NHS Foundation Trust**
1	**CORONER** I am Bridget Dolan, assistant coroner, for the coroner area of West Sussex
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.
3	**INVESTIGATION and INQUEST** On 25 November 2014 the Senior Coroner commenced an investigation into the death of Mrs Wanda Stachurska The investigation concluded at the end of the inquest on 20 May 2015. The conclusion of the inquest was suicide, the medical cause of death being hanging.
4	**CIRCUMSTANCES OF THE DEATH** On 16 November 2014 Mrs Stachurska was brought by ambulance to the Emergency Department ('ED') of East Surrey Hospital (managed by Surrey and Sussex Healthcare NHS Trust 'SASH'). She had been found that day by a member of the public having taken an overdose of 30 sleeping tablets and was attempting to hang herself from a bridge. She was also hypothermic from immersing herself in the cold water of a brook. She informed the ambulance crew that she had been "trying to commit suicide". Mrs Stachurska stayed overnight in the hospital and the following morning she again expressed "suicidal intent" to the ED consultant. At around 17.00 hours that afternoon she was assessed in the ED by mental health nurse from Surrey and Borders Partnership NHS Foundation Trust ('SABP'). That nurse noted Mrs Stachurska now denied suicidal feelings. She considered that there was a low risk of self harm and hence Mrs Stachurska was discharged home at around 19.00 hours. The nurse did not ascertain that Mrs Stachurska had attempted to self-ligature at the bridge the previous day, although this information had been handed over orally by the ambulance staff to the ED triage nurse. The mental health nurse stated that had she known this information it would have been relevant to her risk assessment. Mrs Stachurska was discovered deceased at around 09.00 the following morning, 18 November 2014, having hanged herself from a tree in a park not far from her home. Mrs Stachurska was Polish and had limited command of English, hence her assessment

	by the mental health nurse had to be facilitated through an interpreter. The nurse considered it was important to observe the patient's interaction and non-verbal cues through a face-to-face interpreter. The relevant SASH policy was "to only use interpreters who are bilingually competent, neutral, independent and professionally trained and qualified" and that "the use of staff is not acceptable unless there are exceptional circumstances" (eg emergency situations). The mental health nurse stated that this was not an emergency situation. She also stated that she was not aware of the SASH policy as although she was based at the East Surrey Hospital, where she understood SASH policies would apply, she was not required to be familiar with SASH policies because she was an employee of SABP. The interpreter who was then provided to her by SASH was a Polish man who was employed by a sub-contractor and worked as a security guard at the hospital. The nurse's experience was that the provision of a staff member as a face-to-face interpreter was the norm rather than an exceptional occurrence. It appeared from the nurse's account that the provision of the security guard as an interpreter was sub-optimal in that, although he endeavoured to assist, he did not always directly translate but rather reported a theme of what was being said. Her view was that using a professional interpreter may have improved the quality of her assessment and allowed her to gain more understanding of the nuances of what the patient was saying. Additionally, she stated that if an interpreter had been provided to her who was at least a health care professional this would have been better, because that person would have had more understanding of terms and terminology and the reasons for the assessment. She had in the past completed mental health assessments using members of clinical staff which she had found preferable. Furthermore, it was apparent that the security guard later discussed some information about the patient with another person. It should be noted that although he had been asked by SASH to act as a translator for Polish patients on several other occasions the man had not been given any training or guidance by SASH in respect of how he should carry out this role and the nurse said that he had not been informed about clinical confidentiality in respect of this particular assessment. No serious incident report or review of this death has been conducted by either Trust involved. The mental health nurse had learned of the death from her line manager who she considered was responsible for reporting the incident and could give no explanation why this 'grade 1' serious incident under the SABP policy had not been the subject of a SABP SI review. The ED consultant was of the opinion that a serious incident review was not required under the SASH policy because he believed there had been no omissions or shortcomings in the clinical care provided by SASH.
5	**<u>CORONER'S CONCERNS</u>** 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) That the quality of the mental health risk assessment may be diminished if: (a) Mental health staff are not aware of relevant SASH policies when working at East Surrey Hospital;

	(b) the use of untrained staff as interpreters for mental health assessments is the norm rather than an exceptional or emergency occurrence; (c) staff members who are not health care professionals are asked to interpret during mental health assessments; (d) Staff members who are asked to interpret during mental health assessments are not given any training or guidance as to how to carry out this role. (2) Neither SASH nor SABP had considered that they should undertake a serious incident review into the case despite the death of a patient only a few hours after discharge. (a) An opportunity to learn lessons from the above events has hence been delayed and potentially been lost; (b) To decline to conduct a serious incident review because of a pre-determined opinion that there had been not been any omissions or shortcomings by the organisation might reflect a misunderstanding by SASH of the purpose and value of such investigations.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe your organisations 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 16 July 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: [redacted] I have also sent it to SECAMB, who may find it useful or of interest. 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	**20 May 2015** pp Bridget Dolan [redacted]