Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Rt Hon Matt Hancock, Secretary of State for Health and Social Care, Richmond House, 79 Whitehall, London

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1 CORONER

I am James E THOMPSON, Assistant Coroner for the area of County Durham and Darlington

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 Fifteenth May 2019 I commenced an investigation into the death of Mina TOPLEY-BIRD aged 24. The investigation concluded at the end of the inquest on First April 2021. The conclusion of the inquest was Narrative Conclusion.

Mina Topley-Bird died on 8th May 2019 in Bedroom 4, Elm Ward, West Park Hospital, Darlington by means of hanging by a scarf. Mina had a variety of mental health issues due to past trauma and had previously attempted to take her own life. Mina experienced an episode and was taken to Darlington Memorial Hospital on the night of the 5th of May where she was assessed and then admitted to West Park Hospital in the early hours of the 6th May. The information/documentation from SLAM was not sent on to West Park Hospital, nor did they request this information from Darlington Memorial Hospital or SLAM. This lack of information sharing therefore led to West Park Hospital not having a full understanding of Mina's mental health.

Was there a failure on 8th May 2019 to appreciate that Mina was at increased risk of suicide/self harm following her interaction with a nurse at approximately 2.50pm? YES

Was there a failure on the 8th May 2019 to take precautions against that increased risk in particular, further engagement with her and checks on her? YES

Did the absence of Mina's historic medical records at West Park Hospital hinder staff from appreciating the nature and extent of Mina's implusive behaviour and the risk of rapid deterioration? YES:

I a Hanging

I b

I c

II

4 CIRCUMSTANCES OF THE DEATH

The deceased suffered from a severe and enduring mental illness. She lived in London and

received treatment from the South London & Maudsley NHS Trust (SLAM) from 2017. She had attempted suicide/self harm on previous occasions. She was prone to impulsive behaviour in terms of her suicide/self harm attempts.

She travelled to the North East of England in May 2019 to perform and after an event in Newcastle Upon Tyne she returned to London by train on 5th May 2019. She suffered a mental health episode and left the train at Darlington. She attempted to run in front of moving traffic and was taken to Darlington Memeorial Hospital. Whilst awaiting treatment she attempted to stab herself in the neck with a pen.

She was assessed and admitted feeling suicidal. She agreed to be admitted to West Park Hospital (part of the Tees Esk & Wear Valleys NHS Foundation Trust - TEWV) for treatment. Prior to assessment process SLAM on TEWV request sent the deceased's recent medical history and information regarding previous self harm and other safeguarding information. A total of 3 documents were sent attached to an email. Only 1 attachment was read. The information was précised and added to the TEWV medical notes system - PARIS. The 3 documents were not forwarded to any staff at West Park Hospital.

The TEWV staff were unable to print the information they received from SLAM due to the IT system operated by TEWV not being able to allow it to print on other NHS Trusts hardware when they share premises.

When the deceased was a patient at West Park Hospital, attempts were made to locate a bed for the deceased in London, but none were available.

On 8th May 2019 at approximately 2.50pm the deceased approached a nurse at West Park Hospital and enquired if a bed had been found for her in London. When informed none was available, the deceased replied words to the effect 'I may as well kill myself'. The deceased was spoken to by the nurse as a result of her statement. The deceased ended the discussion and returned to her room. She was discovered hanging by a scarf secured in the hinge of the bathroom door in her room at approximately 3.55pm and pronounced death at 4.33pm.

5 CORONER'S CONCERNS

The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)

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

On the evidence heard at inquest, it appears when a patient is admitted to a bed within a Mental Health Trust out of their normal locality (in this case County Durham, when the patient lived in London) there was no national policy to co-ordinate the transfer of patients back to their 'Home' area. It appears there was no agreed escalation policy when a bed could not be obtained and no agreed process to 'apply' for a bed in another Trust area. It is of concern as the arrangements at the present time seem to be ad Hoc in nature and may as such create delay in any transfer of patients.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your

organisation) 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 02 June 2021. 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]
Ward Hadaway Solicitors on behalf of Tees, Esk &Wear Valley NHS Foundation Trust
Bevan Brittan Solicitors on behalf of South London & Maudsley NHS Foundation Trust
DPG Law on behalf of [redacted]
Chief Executive, Tees, Esk and Wear Valley NHS Foundation Trust,

And

Care Quality Commission

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.

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James E THOMPSON
Assistant Coroner for
County Durham and Darlington
Dated: 07 April 2021

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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THIS REPORT IS BEING SENT TO:

1 [redacted], Chief Executive, Tees, Esk and Wear Valley NHS Foundation Trust, West Park Hospital, Edward Pease Way, Darlington

1 CORONER

I am James E THOMPSON, Assistant Coroner for the area of County Durham and Darlington

2 CORONER'S LEGAL POWERS

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3 INVESTIGATION and INQUEST

On Fifteenth May 2019 I commenced an investigation into the death of Mina TOPLEY-BIRD aged 24. The investigation concluded at the end of the inquest on First April 2021. The conclusion of the inquest was Narrative Conclusion - Was there a failure on 8th May 2019 to appreciate that Mina was at increased risk of suicide/self harm following her interaction with a nurse at approximately 2.50pm? YES
Was there a failure on the 8th May 2019 to take precautions against that increased risk in particular, further engagement with her and checks on her? YES
Did the absence of Mina's historic medical records at West Park Hospital hinder staff from appreciating the nature and extent of Mina's implusive behaviour and the risk of rapid deterioration? YES:

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4 CIRCUMSTANCES OF THE DEATH

The deceased suffered from a severe and enduring mental illness. She lived in London and received treatment from the South London & Maudsley NHS Trust (SLAM) from 2017. She had attempted suicide/self harm on previous occasions. She was prone to impulsive behaviour in terms of her suicide/self harm attempts. She travelled to the North East of England in May 2019 to perform and after an event in Newcastle Upon Tyne she returned to London by train on 5th May 2019. She suffered a mental health episode and left the train at Darlington. She attempted to run in front of moving traffic and was taken to Darlington Memeorial Hospital. Whilst awaiting treatment she attempted to stab herself in the neck with a pen. She was assessed and admitted feeling suicidal. She agreed to be admitted to West Park Hospital (part of the Tees Esk & Wear Valleys NHS Foundation Trust - TEWV) for treatment. Prior to assessment process SLAM on TEWV request sent the deceased's recent medical history and information regarding previous self harm and other safeguarding information. A total of 3 documents were sent attached to an email. Only 1 attachment was read. The information was précised and added to the TEWV medical notes system - PARIS. The 3 documents were not forwarded to any staff at West Park Hospital. The TEWV staff were unable to print the information they received from SLAM due to the IT system operated by TEWV not being able to allow it to print on other NHS Trusts hardware when they share premises.

When the deceased was a patient at West Park Hospital, attempts were made to locate a bed for the deceased in London, but none were available. On 8th May 2019 at approximately 2.50pm the deceased approached a nurse at West Park Hospital and enquired if a bed had been found for her in London. When informed none was available, the deceased replied words to the effect 'I may as well kill myself'. The deceased was spoken to by the nurse as a result of her statement. The deceased ended the discussion and returned to her room. She was discovered hanging by a scarf secured in the hinge of the bathroom door in her room at approximately 3.55pm and pronounced death at 4.33pm.

5 CORONER'S CONCERNS

The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)

1. Evidence was heard that medical records and other important information could not be uploaded to the Trust's electronic notes system - PARIS when received in PDF form. This meant staff had to precis notes onto the system, in this case when one person was working alone, on a nightshift was required to do this whilst dealing with a variety of different tasks. Important documents that cannot not to be uploaded immediately and in their original form concerns me that attending clinicians do not have access to these documents and can be hindered in making clinical decisions without them.

2. It became apparent on the evidence that whilst Trust staff were working in premises operated by another Trust (in this case, County Durham and Darlington NHS Foundation Trust - CDDFT) they could not print medical notes and other documents from the TEWV IT system onto printers in 'shared' premises such as the A&E Department of the CDDFT. This again meant important documents can be unable to be shared with staff undertaking such tasks as Mental Health Assessments.

3. The Trust (TEWV) in evidence heard that the Elm Ward at West Park Hospital had been surveyed for issues related to patient safety such as ligature points. Whilst the evidence was that the Trust was confident this had been done, no assurance could be given. One such assessment did not show clearly if the deceased's bedroom had been inspected for issues such as ligature points.

4. Evidence was heard that within the Durham & Darlington area of the TEWV Trust funding had been secured for the post of a Bed Manager, who was to manage bed allocation, transfer and discharges to better manage access to beds for patients across this area of the Durham & Darlington area of the Trust. It was heard this role would be able to more proactively arrange transfers of patients from Trust to Trust as was a need raised in this inquest. It was disclosed that this post only operated in the Durham & Darlington area of the Trust and not across the whole Trust. On the evidence heard this post has obvious benefits for ensuring patients access to beds and I raise a concern this post is not one which cover the whole of the Trust, only one region of it.

5. The Trust gave evidence that the Risk Assessment/Safety Summary process for assessing and protecting patients had been improved, but accepted it was still ' a work in progress' and further work was required. It is of concern that this aspect of area of patient safeguarding appears on the evidence given at inquest not to be complete.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.

7 YOUR RESPONSE

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And

Rt. Hon Matt Hancock, Secretary of State for Health and Social Care
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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

James E THOMPSON
Assistant Coroner for
County Durham and Darlington
Dated: 09 April 2021