Derek Winter DL
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: -** **The Rt Hon Jeremy Hunt MP** **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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 14th April 2015 I commenced an Investigation into the death of Elsie Tindle, aged 71 years. The investigation concluded at the end of the Inquest on 3rd March 2016. The conclusion of the Jury Inquest was that she died 'as a result of a rare complication following the lawful and necessary administration of ECT'.
4	**CIRCUMSTANCES OF THE DEATH** Elsie Tindle had a complex personal and medical history. Miss Tindle was particularly close to her sister with whom she had lived. Miss Tindle had a psychiatric diagnosis of Depressive Disorder of a severe degree with a suspected underlying cognitive impairment and a learning disability. On 23rd February 2015 Miss Tindle was made subject to section 3 of the Mental Health Act 1983 (MHA). Miss Tindle received Electro Convulsive Therapy (ECT) on 27th February 2015, 6th March 2015 and 9th March 2015. On 23rd February 2015, a paper request for a Second Opinion Appointed Doctor (a SOAD) was made to the Care Quality Commission (CQC) and then subsequently online to the CQC, who acknowledged it the following day.

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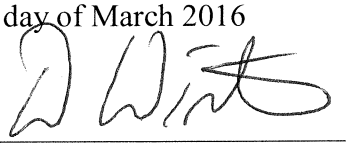
	It appears that no SOAD was ever allocated and that the request was not followed up. Miss Tindle had 3 sessions of ECT over an 11 day period as it was believed that the s62 MHA criteria had been made out in that it was immediately necessary to save the patient's life or prevent a serious deterioration in her condition. Miss Tindle was removed from the section 3 on 11th March 2015. Miss Tindle developed focal seizures and status epilepticus, which required her transfer to the High Dependency Unit of Sunderland Royal Hospital, and she was then discharged back to the ward at the Hospital on 16th March 2015. On 19th March 2015 Miss Tindle was made subject to a Deprivation of Liberty Safeguard. By 29th March 2015 Miss Tindle appeared to develop aspiration pneumonia and, although she was treated with antibiotics, her decline continued and she died on 4th April 2015. Post-Mortem Examination on 14th April 2015 gave the cause of death for Miss Tindle as: 1a Anoxic-Ischaemic Brain Damage Due to 1b Status Epilepticus Due to 1c Electro-Convulsive Therapy
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. – (1) I heard evidence that the present compliment of SOADs is approximately 105 and that in 2014/15 they carried out 14,373 visits. 25% of cases with a SOAD led to changes in a treatment plan and in 3% of cases the SOAD did not approve the plan. The SOAD safeguard in theory can prevent the inappropriate use of ECT. (2) For ECT, SOADs attend within 5 days in 82% of cases but I am concerned that in 1:5 cases this does not happen. (3) Practitioners anticipate delays with the appointment of SOADs and it is common to use the urgent powers under s62 MHA (it is immediately necessary to save the patient's life or prevent a serious deterioration in their condition). (4) I am concerned that there is a danger of the use of s62 MHA becoming a default position and that the numbers of SOADs may be insufficient to deal with matters in a more timely way. (5) I was encouraged to hear that each of the agencies had reviewed practices and procedures, particularly Northumberland Tyne and Wear NHS Foundation Trust, who were to set up a system for the treating Psychiatrist to chase the CQC in the absence of a

	timely appointment of a SOAD.
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 5th May 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: - • Sunderland City Council and their Solicitors • Northumberland Tyne and Wear NHS Foundation Trust by their Counsel and Solicitors • Care Quality Commission • Official Solicitor • Sunderland Royal Hospital [redacted] 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 8th day of March 2016 Signature  Senior Coroner for the City of Sunderland