Newcastle upon Tyne Coroners
MISS KARIN WELSH
HM ASSISTANT SENIOR CORONER
Civic Centre, Barras Bridge, Newcastle Upon Tyne, NE1 8QH
[redacted]

Date: 10th December 2021
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

[redacted]
Chief Executive
City Hospitals Sunderland NHS Foundation Trust
Sunderland Royal Hospital
Kayll Road
Sunderland SR4 7TP

1. CORONER

I am **Miss Karin Welsh, Assistant Coroner for Newcastle**

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 the 10th December 2021 I concluded an inquest into the death of Edward Cockburn an 81 year old gentleman who died at Royal Victoria Infirmary Newcastle upon Tyne on 25th March 2020. He had fallen from an upper storey window in what should have been a locked sluice room on Ward B21 at Sunderland Royal Hospital on 15th March 2020. The medical cause of death was:

1a Acute bronchopneumonia due to

1b multiple injuries

1c

II Coronary artery atheroma Covid 19 infection

My conclusion was that Mr Cockburn had died as a result of a fall from a window in what should have been a secure sluice room the door of which had been propped open. The fall would have been prevented by appropriate and timely enhanced care risk assessments resulting in one to one observations. This amounted to neglect and occurred at a time of unrecognised and significant substandard staffing levels

4. CIRCUMSTANCES OF THE DEATH

Edward Cockburn had been admitted to Sunderland Royal Hospital on 12th March 2020 for treatment for inter alia pneumonia. He was transferred to Ward B21 on 13th March 2020. Assessments pursuant to the Trusts Standard Operating Procedure for Enhanced Care/Observation were not carried out after 02.44 on 14th March 2020 despite further episodes of confusion including an incident when Mr Cockburn barricaded himself and five other patients into Bay 3 on Ward 21. This resulted in a failure to instigate level 4 observations most particularly after this incident. This enabled Mr Cockburn to access what should have been a locked sluice room because it had been propped open and fall from a window within. The fixing used to secure a Jackloc Mark 2 restrictor on the window failed This was at a time when staffing levels were significantly substandard. Mr Cockburn subsequently died from injuries sustained in the fall

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.

Staff appeared to be unaware of the Trusts Standard Operating Procedure in relation to Enhanced Care/Observation. Training at that time had not been given to relevant members of staff in connection with the SafeCare system. Whilst training and information had been cascaded there was no procedure in place in relation to any training that could record and thereafter audit the efficacy of that system with particular regard to when the training was delivered and by whom and to whom it was delivered.

6. ACTION SHOULD BE TAKEN

The following action is required to avoid future deaths:

(a) Create a procedure to record details of training delivered, when and to whom
(b) Create a system to audit that procedure so as to ensure that all training has been delivered to all staff

7. YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report namely 4th February 2022. 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:

- Family
- South Tyneside and Sunderland NHS Trust and their solicitor

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.

10 December 2021

Karin Welsh HM Assistant Coroner for Newcastle upon Tyne

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Civic Centre, Barras Bridge, Newcastle Upon Tyne, NE1 8QH
[redacted]

Date: 10th December 2021
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

[redacted]

Managing Director

The Jackloc Company Limited

Alma Park

Woodway Lane

Claybrooke Parva

Lutterworth

LE17 5BH

1. CORONER

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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 fixing was attached to the sill of the window in accordance with fitting instructions issued by your Company and dated July 2017. Subsequent to the installation a data sheet was issued indicating that the fixing should be attached to the window frame only. This change in data/guidance was not highlighted to South Tyneside and Sunderland NHs Trust and presumably other hospital trusts. The position of the fixing on the sill enabled the restrictor to be more readily defeated bearing in mind this was a pivot window

6. ACTION SHOULD BE TAKEN

The following action is required to avoid future deaths:

(a) To ensure that the guidance is changed clarify the necessity to attach the fixing to the frame and proximity to the points of pivot
(b) To ensure that this is effectively communicated to and highlighted with all NHS Trusts and other relevant users using the Jackloc window restrictor system

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[redacted]

Date: 10th December 2021
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THIS REPORT IS BEING SENT TO:

Rt Hon Sajid Javid MP
Secretary for State for Health and Social Care
Department for Health and Social Care
39 Victoria Street
London SW1H 0EU

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The fixing was attached to the sill of the window in accordance with fitting instructions issued by Jacklok and dated July 2017. Subsequent to the installation a data sheet was issued indicating that the fixing should be attached to the window frame only. This change in data/guidance was not highlighted to South Tyneside and Sunderland NHs Trust and presumably other hospital trusts. The position of the fixing on the sill enabled the restrictor to be more readily defeated bearing in mind this was a pivot window.

Jacklok have been requested to take action as follows

(a) To ensure that the guidance is changed clarify the necessity to attach the fixing to the frame and proximity to the points of pivot
(b) To ensure that this is effectively communicated to and highlighted with all NHS Trusts and other relevant users using the Jackloc window restrictor system

The relevant Department guidance is Health Building Note 00-10Part D Windows and Associated Hardware

6. ACTION SHOULD BE TAKEN

The following action is required to avoid future deaths:

To consider the issues raised with Jacklok and review the relevant guidance accordingly

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