Andrew Hetherington
HM Senior Coroner for North Northumberland and
Acting Senior Coroner for South Northumberland

Northumberland Coroner's Court
County Hall, Morpeth, Northumberland NE61 2EF
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Secretary of State for Health and Social Care
1	**CORONER** I am Andrew Hetherington, Senior Coroner, for North and South Northumberland
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 6 October 2020 I commenced an investigation into the death of Charley Ann Patterson. The investigation concluded at the end of the inquest. The inquest started on Tuesday 11 October 2022 and concluded today, Friday 14 October 2022. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** Charley Ann Patterson Deceased suffered with low mood and anxiety related to a number of factors including the restrictions in place due to COVID-19, relationship difficulties with peers and other influences. She had suffered bullying in the period leading up to her death through electronic means. She shared two known previous instances of self-harm involving cutting to her arms which were superficial in nature. She voluntarily attended Northumbria Specialist Emergency Care Hospital, Cramlington with her mother at approximately 20.00 hours on 29th May 2020 after she had self-harmed for the second time a few days prior. She was assessed and promptly referred to and seen by the Psychiatric Liaison Team at approximately 21.30 hours. There were superficial cuts to the left arm which did not require medical intervention and she wanted support with her anxiety and low self-esteem and to learn positive coping strategies for times of emotional distress due to a number of factors. As part of the discharge plan on 29 May 2020 she was referred to the Young Persons Universal Crisis Team and an assessment with them took place upon agreement via telephone on 1 June 2020. She did not meet the criteria for referral to Children and Young Peoples Service as she did not present with a significant degree of psychological distress or mental health difficulty. She was discharged with support netting and a plan where it was discussed and agreed with her and her mother that there would be a referral to the Northumberland (Early Help) Hub. No referral to the Northumberland (Early Help) Hub was made. There was no referral to the mental health trust safeguarding team and there was an absence of communication

	with other services and professionals although it is not possible to say if those referrals and steps had been undertaken whether the outcome would have been any different. [redacted] Cardiopulmonary resuscitation was commenced, and paramedics arrived, and a return of spontaneous circulation was achieved. She was conveyed by ambulance to Northumbria Specialist Emergency Care Hospital, Cramlington and upon arrival was in cardiac arrest. Despite continued attempts at resuscitation life was confirmed extinct at 19.31 hours on 1 October 2020 within Northumbria Specialist Emergency Care Hospital, Cramlington. Charley Ann Patterson had left a number of drawings and a note with references to the intention of ending her life.
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) During the course of the inquest, it was a concern to me the increase in the number of children and young people who are now being seen with regard to their emotional well-being, psychological distress and mental health difficulties which have impacted on them requiring support and assessment since the Coronavirus pandemic and the delays that now exist before they receive treatment and support. (2) I heard that in 2020 if the criteria for referral had been met for referral to Children's Adolescent Mental Health Services there would have been a triage of the child or young person within 8 weeks, treatment within up to 19 weeks with the number of referrals at that time being 1,595. In 2022, subject to meeting the criteria for referral, there would be a triage of the child or young person within 3 weeks but that the waiting time for treatment has increased from up to 19 weeks to up to 63 weeks with the number of referrals being 2,275. (3) I heard evidence from Cramlington Learning Village where Charley was a pupil and they told me since Charley's death they have strengthened their support for children suffering from anxiety and other mental health issues by increasing the mental health team, employing two emotional literacy teaching assistants, a Mental Health and Well Being Practitioner, another Thrive Practitioner and increased the number of Deputy Safeguarding Leads to 5. (4) I heard from a Paediatric Nurse Practitioner who is based in the Accident and Emergency at Northumbria Specialist Emergency Care Hospital, Cramlington who told me in evidence that in 2020 it was the case that she would see a referral from a child or young person struggling with emotional distress, anxiety, mental health difficulties and instances of self-harm and overdose once a week but that since the Coronavirus pandemic the incidence of assessments for children and young people with those issues has risen from once per week to once per shift. I also heard from the Group Nurse Director for Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust in the North Locality who told me that in May 2020 she would see 100 referrals a month from children experiencing anxiety and mental health difficulties but in May 2022 the number of referrals has increased to 300 children per month. The reason for the referrals is complex but includes the impact of the Coronavirus pandemic with staff seeing an increase in demand in the numbers of young people suffering with anxiety, low self-esteem, bod image, OCD and instances of self-harm and overdose. (5) I ask for there to be an assessment of the services and resources that can be offered to meet the increase in demand in the number of children and young people seeking support with regard to their emotional well-being, psychological distress and mental health difficulties which have impacted on them since the Coronavirus pandemic and to reduce the delay in receiving early support in order to avoid a mental health crisis.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, Dr Coffey, have the power to take such action.
	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 9th December 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; [redacted] Cumbria, Northumbria, Tyne and Wear NHS Foundation Trust, Dr [redacted] Cramlington Medical Group and Cramlington Learning Village, and to the Northumberland Safeguarding Children Board. 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	**DATE 19 October 2022** A. P. Hetherington **Andrew Hetherington** **HM Senior Coroner for North Northumberland and Acting Senior Coroner for South Northumberland**