Kally Cheema LLB | Senior Coroner | Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

7 June 2023

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: CEO Cumbria, Northumberland, Tyne and Wear NHS Trust

1	**CORONER** I am Dr Nicholas Shaw, HM Assistant Coroner for Cumbria
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 15 December 2022 I commenced an investigation into the death of Brenda SHIELDS age 57. The investigation concluded at the end of the inquest on 6th June 2023 . The conclusion of the inquest was: Death from self-suspension while her cognition was seriously impaired by a very high blood alcohol level. 1a Hanging 1b 1c II Alcohol dependence
4	**CIRCUMSTANCES OF THE DEATH** The record of inquest read as follows: "Brenda Shields died in her home , Carlisle on 8th December 2022. She took her life by ligature suspension while under the influence of a very high blood alcohol level". A narrative conclusion was given.

Brenda worked as a healthcare assistant in A&E at Cumberland Infirmary, she had for some time been alcohol dependent with binge sessions which often caused domestic friction with her husband, there was an incident of domestic violence requiring police involvement. Matters had been worse since she developed cauda Equina Syndrome which required neurosurgical intervention in 2021, and had ongoing low back pain which she tended to medicate with alcohol. She had had episodes of anxiety in 2005 & 2007, depression on 2016 & suicidal ideation in 2018. On 26/10/22 she was admitted to A&E in Carlisle (her own workplace) with an intentional overdose. She was followed up and treated by her GP. On 10/11/21 there was a serious incident when she was found by police on the riverbank, she had intended to enter the water but was talked down from this by her GP. Brenda was admitted to hospital [Hadrian unit] as a voluntary patient.

Brenda was not comfortable in the ward environment and on 14/11/21 discharged home to be followed up by the Crisis Team who did visit her at home the following day. Brenda's GP was not informed of her admission or discharge so was unaware of events until a prearranged telephone call on the 15th. Brenda was followed up at home and by telephone, at several contacts she was noted to be under the influence of alcohol. Brenda was discharged after a final "MDT" meeting on 6/12/22 [it is not clear who was involved], declining further input and denying any thoughts of self harm, a risk assessment on 8/12/22 records low or no apparent risks, this was the day Brenda died.

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.

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The **MATTERS OF CONCERN** are as follows. –

[BRIEF SUMMARY OF MATTERS OF CONCERN]

(1) Brenda was discharged without any planned follow up. Her family were not involved in the discharge process despite assurances that they would be, her GP did not receive discharge notification from the Hadrian unit until 8 days after the event or from the Crisis team until 10 days after Brenda's death. Referrals promised from Hadrian unit to Drug/Alcohol services and Persistent Physical Symptoms Service were not made.

(2) Inadequate weight seems to have been given to Brenda's alcohol problems and her assurances that all was, and would continue to be well were accepted at face value despite her recent history, her family find it hard to understand how she could be graded low risk on the day she died.

(3) I refer you to the PFD report I issued referring to Charlotte Grace on 29/10/19. Assurances were given in response to that report which again focused on discharge without family/carer involvement which is surely paramount. I note actions mentioned in the incident report in this case but am still concerned that similar events may occur in future.

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ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and the wider trust have the power to take such action.

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YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report,

namely by 2nd August 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons : Brenda's family and her GP [redacted] of Eden Medical Group, Carlisle

8 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.

7 June 2023

9 Signature

Dr Nicholas Shaw HM Assistant Coroner for