Kally Cheema LLB | Senior Coroner | Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

[redacted]

[redacted]

2 May 2024

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: North Cumbria Integrated Care NHS Foundation Trust
CORONER

1 I am Mr Robert Cohen, HM Assistant Coroner for Cumbria

CORONER'S LEGAL POWERS

2 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

INVESTIGATION and INQUEST

On 8 November 2023 I commenced an investigation into the death of Karen THOMASON. The investigation concluded at the end of the inquest on 2nd May 2024. The conclusion of the inquest was

Alcohol related death.

3 The Medical Cause of death was:

1a Acute Ethanol Toxicity

1b

1c

II

CIRCUMSTANCES OF THE DEATH

4 Karen Thomason was 52 years old. She lived at in Carlisle, Cumbria. Ms Thomason was alcohol dependent. She had been admitted to the Cumberland Infirmary, Carlisle on numerous occasions as a result of her use of alcohol. On any view Ms Thomason lived a

'highly risky lifestyle' (as one of the treating clinicians described it in evidence).

Cumbria Housing staff had previously asked that Ms Thomason should not be discharged from hospital without them being notified. This was so that they could ensure that she did not arrive home without any support.

On 31st October 2023 Ms Thomason collapsed at home and was taken to hospital. She was discharged at 21:02 on 31st October. Cumbria Housing staff were not informed of her discharge. The next day, on 1st November 2023 Ms Thomason was found unresponsive at home. Her death was confirmed by ambulance staff at 12:03. Ms Thomason had consumed a substantial amount of alcohol, and this caused her death.

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) There were errors in the completion of the hospital's safeguarding questions. The clinician answered 'no' to the question 'Is there a safeguarding concern?'. The clinician's evidence was that, in fact, she did have a safeguarding concern and explored it with Ms Thomason, but that she completed the electronic form in error. I am concerned that the
5 form is regarded as a 'tick box' exercise rather than a vital safeguarding tool.

(2) There is evidence that Cumbria Housing staff had asked to be notified of the discharge of a vulnerable patient so that they could provide support to her but that they received no communications on several occasions. I am concerned that this may mean that other patients are discharged without appropriate support being alerted to their needs.

(3)The evidence I received places an emphasis on the fact that Ms Thomason had capacity and indicated that she felt safe. It is certainly correct that this meant that there could be no question of her being held in hospital. It is also correct that her view of her situation was of relevance. However, it does not mean that obvious vulnerability or safeguarding concerns could not be addressed. Regardless of what Ms Thomason said, her vulnerability was obvious. I am concerned that the concepts of 'having capacity' and 'not being vulnerable' are being elided.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you 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,
7 namely by 27th June 2024. 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 Ms Thomason's mother and to [redacted] of Cumbria Housing who may find it useful or of interest.

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.

2 May 2024

9 

Signature

Robert Cohen HM Assistant Coroner for