ANDREW HETHERINGTON
H M Senior Coroner for Northumberland

County Hall, Morpeth, Northumberland NE61 2EF
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust**
1	**CORONER** I am Andrew Hetherington, Senior Coroner for 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. http://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** I commenced an investigation into the death of Elise Walsh Deceased. The investigation concluded at the end of the inquest on 20 August 2024. The conclusion of the inquest was a narrative conclusion: The deceased died after [redacted] on 12 February 2022. The act was deliberate on her part intending the result being to end her life. She suffered severe hypoxic brain injury which left her severely debilitated and died on 7 June 2023. The cause of death was: 1a Aspiration pneumonia 1b Hypoxic ischemic encephalopathy secondary to hanging

4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of self-harm and suicidal ideation. On 28 January 2022 she approached police and expressed suicidal ideation. She was seen by the Psychiatric Liaison Service and referred to the Crisis Resolution and Home Treatment Team. She voluntarily attended appointments at St George's Park Hospital for home treatment with transport to and from appointments provided by taxi. She attended an appointment at St George's Park Hospital on the 12 February 2022. She entered the waiting area toilets and after approximately 16 minutes staff entered and found she had [redacted] CPR was commenced and she was conveyed to the Royal Victoria Infirmary, Newcastle upon Tyne where it was identified she had sustained a severe hypoxic brain injury which left her severely debilitated bedbound, non-verbal and was fed via a percutaneous gastrostomy tube. She was a resident at Heatherfield Care Home and dependent on staff for all her needs. She became unwell on 4 June 2023 having developed aspiration pneumonia and was admitted Northumbria Specialist Emergency Care Hospital, Cramlington where she died on 7 June 2023.
5	**CORONER'S CONCERNS** **1.** The deceased attended an appointment at St George's Park Hospital on the 12 February 2022. After the appointment she was waiting for a taxi, walking up and down the corridor and appeared to be getting more agitated. She was not happy with how her appointment went and voiced those concerns verbally. When the taxi arrived, she refused to get in and the taxi left. She remained at reception where she voiced her anger at the Crisis Team and requested a Complaints Form. I describe it as a note of intent and do not repeat its content. It is not referred to in any witness statements, it is not referred to in the Serious Incident Investigation. I heard it was discussed at the After Action Review but it has not made its way through to the Serious Incident Investigation. It was disclosed to my office on Friday 16 August 2024 and of greater concern

	the family were not aware of its existence. I am concerned this significant information was not made available much earlier. 2. I am told the administrative staff do not read complaint forms and it is the process that complaint forms are placed in an envelope without being read or considered and are sent straight to another hospital. However it appears as part of the triage the envelope containing the complaint form is opened at that hospital by a mixture of administrative staff and clinical staff. I am concerned that important information from a patient could be missed and there could also be a significant delay in administering treatment or intervention.
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 17 October 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons The family of Elise Walsh Deceased. 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 22/08/24 Signed: A. P. Hetherington Andrew Hetherington HM Senior Coroner for Northumberland