

St Nicholas Hospital  
Jubilee Road  
Gosforth  
Newcastle upon Tyne  
NE3 3XT

David Place  
HM Assistant Coroner for Sunderland

Dear Sir

**Inquest into the death of John Paul Hurst**  
**Regulation 28 Report to Prevent Future Deaths Response**

Cumbria Northumberland Tyne and Wear NHS Foundation Trust would like to express our deepest condolences to the family of John Hurst. We take all patient deaths very seriously and investigate them thoroughly to establish if lessons can be learned or services can be improved. Your concern has made us reflect further on any additional learning and I will expand on it in the letter below.

Your concern was as follows:

***'At the Inquest I heard evidence that, following John's arrest, concerns were expressed by police officers involved in the investigation as to his mental health, and by John's sister as to his risk of ending his own life. These concerns were repeated by John's sister to the Criminal Justice Liaison and Diversion Service (CJLD) prior to his assessment. The evidence was that when completing the release risk assessment, the custody sergeant had been greatly assisted by the information recorded on the electronic custody record regarding the concerns that led to the mental health assessment and the assessment itself, in addition to the custody sergeant's own observations. The evidence highlighted that the electronic custody record contained limited information about the concerns of police officers and John's sister, and there was a distinct lack of detail about the assessment itself and very little analysis of the concerns and reasoning for the CJLD conclusion.'***

***I am concerned that the information on the electronic custody record was inadequate and lacked detail regarding the concerns for the detained person's mental health, as identified by police officers and family, including the risk of suicide, the content of notes found and the detained persons history of suicidal ideation and previous engagement with mental health services. In addition, I am concerned that the record also lacked a detailed analysis of those concerns by CJLD and comprehensive reasoning for the assessment conclusion.'***

***Deaths may be prevented if the recording of information in such cases is reviewed.'***

The Trust has carried out a thorough review of the guidance provided to staff in relation to entering information onto the electronic custody record and the following changes have been embedded:

### **Local Operating Procedure**

The Criminal Justice Liaison and Diversion Team (CJLD) Local Operating Procedure has been updated and now provides clear and robust guidance to staff regarding the information which must be recorded on the electronic custody record following a screening assessment.

The Local Operating Procedure requires staff to consider the following:

- If the Detained Person (DP) is known to CNTW services, how long they have been known and if they are open to a care team currently.
- If they are open to a care team, are they engaging and when were they last reviewed.
- Have they had any previous admissions to psychiatric hospital.
- Does the DP have a diagnosis.
- Are they prescribed any medication, and if so, are they compliant.
- If the DP engaged in a screening.
- Mental state at time of screening. Please be explicit in evidencing why there is no evidence of a mental state deterioration or mental health crisis.
- Reference of your clinical decision making if you do not clinically share the concerns outlined in the referral.
- Risk to self, including any historical risks of suicide, self-harm and mental health deterioration.
- Risk to others, and risk from others.
- Any risk mitigations.
- Onward referral pathways, and there is no onward referral, why (i.e. did not want any support etc).
- If they need an appropriate adult.
- If you have spoken with a carer, any concerns they may have.
- **\*\*Please document that you have verbally handed over to the custody sergeant and include their collar number.\*\***
- What information you have placed with the DP's property.
- That they can be referred back to CJLD if required.

The above guidance is expected to be considered in addition to a verbal handover to the Custody Sergeant which already takes place.

The updated Local Operating Procedure was circulated to staff on 12 November 2024 via email, please see "Exhibit A". Team training also took place on the 13 November 2024 to discuss the updated guidance. During

the training discussion took place explaining the Regulation 28 and associated concerns. Advice was given with regards to information which must be recorded on ECR by CJLD practitioners following screening assessment, as outlined in Local Operating Procedure. Staff were instructed that verbal handover must always be given to the Custody Sergeant following screening assessment. Collar number of Custody Sergeant receiving handover must be recorded on RiO and ECR. Staff were given opportunity to ask questions, and confirmation was sought that changes to Local Operational Procedure were understood.

Please see the updated Local Operating Procedure document at "Exhibit B".

### **Clinical Audit Tool**

In addition, CJLD Clinical Leads have been given express permission by the Northumbria Police (Superintendent responsible for Custody), to audit Trust staff entries into the electronic custody record provided the reason for accessing the record is documented. Clinical Audit of CJLD screening documentation is and will be carried out by CJLD Clinical Leads monthly for every staff member. Three random samples are selected for each staff member each month. Audit includes records made on both ECR and RiO. Audit outcomes are and will be discussed in monthly Clinical Supervision.

Regular random audits will identify any issues with staff entries onto the electronic custody record and will ensure that changes are being embedded and improvements monitored.

Please see the updated Clinical Audit of CJLD screening tool documentation at "Exhibit C".

We hope that the above is helpful in addressing your concerns. We are also happy to engage with you to discuss any issues or concerns generally, as we try to with all coroners in local areas. Please let us know if that would be of any use.

Yours faithfully

A black rectangular box used to redact the signature of the Medical Director or Deputy Chief Executive.

**Medical Director / Deputy Chief Executive**

## **EXHIBIT A**



EXHIBIT A - Email to  
CJLD\_Redacted.pdf

## **EXHIBIT B**



EXHIBIT B - CNTW  
LD MHTR Processes

## **EXHIBIT C**



EXHIBIT C - Clinical  
Audit Tool 2024\_Rec