REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS ENGLAND** **2. DERBY AND BURTON HOSPITAL** **3. ROYAL STOKE UNIVERSITY HOSPITAL**
1	**CORONER** I am Emma Serrano, Acting Senior Coroner, for the coroner area of the Staffordshire.
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 the 10 January 2024 2017, I commenced an investigation into the death of Miss Alix Elizabeth Knowles. The investigation concluded at the end of the inquest on 2 October 2024. The conclusion of the inquest was a short form conclusion of: Suicide The cause of death was: 1a Multiple Traumatic Injuries 1b Fall
4	**CIRCUMSTANCES OF THE DEATH** i) Miss Knowles was 30 years of age, with in life diagnosis of Emotionally Unstable Personality Disorder and Bi-Polar effective disorder. ii) She had previously expressed suicidal thought and attempted to take her own life. iii) On the 8 December 2023 she attended the Queens Hospital, Burton Upon Trent, Accident and Emergency department via ambulance. Information given to the department by paramedics was that she had attempted to cut her throat and was threatening to commit suicide. iv) On the 8 December 2023 she was seen by the Mental Health Liaison team, to consider detention under the Mental Health Act. The mental health liaison team were not aware of the reasons for her attendance to A&E, because bank staff are not allowed access to the electronic computer system. The mental health liaison team made the decision that she would not be detained under the mental health act, and she was discharged home. v) It was heard in evidence that Hospital Trusts cannot access other hospital trusts patient notes, because of the use of different computer systems. vi) In the early hours of the 9 December 2023, Alix Elizabeth Knowles made her way to the bridge above the [redacted], where she

	jumped onto the road below and was hit by two motor vehicles.
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. Bank Staff are not able to access patient notes before assessments; 2. Different NHS Trusts are unable to access patient notes, because the computer systems used do not allow this.
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 20 November 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; Family. 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	**2 October 2024** **Miss Emma Serrano** **Acting Senior Coroner** **Staffordshire**