David Place
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **NHS England**
1	**CORONER** I am David Place, His Majesty's Senior Coroner for the City of Sunderland
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 10th April 2025 I commenced an Investigation into the death of Hollie Elizabeth Loraine, who died in Washington on 30th August 2025 aged 27 years. The Investigation concluded at the end of the Inquest on 27th March 2026. The medical cause of death was confirmed as: - Ia Pressure to the neck Ib Hanging II Alcohol Intoxication I gave a conclusion of Misadventure.
4	**CIRCUMSTANCES OF THE DEATH** Hollie Elizabeth Loraine had a long history of mental health concerns compounded at times by her use of alcohol in binge patterns and included suicidal ideation and numerous previous attempts to end her life. She died at her home address in Washington, Sunderland on 30th August 2025 by hanging from the loft hatch using a ligature made from a dressing gown belt having consumed a large quantity of alcohol in the period leading up to her death which was found to be at a level which, on the balance of probabilities, is likely to have significantly affected her state of mind.
5	**<u>CORONER'S CONCERNS</u>** 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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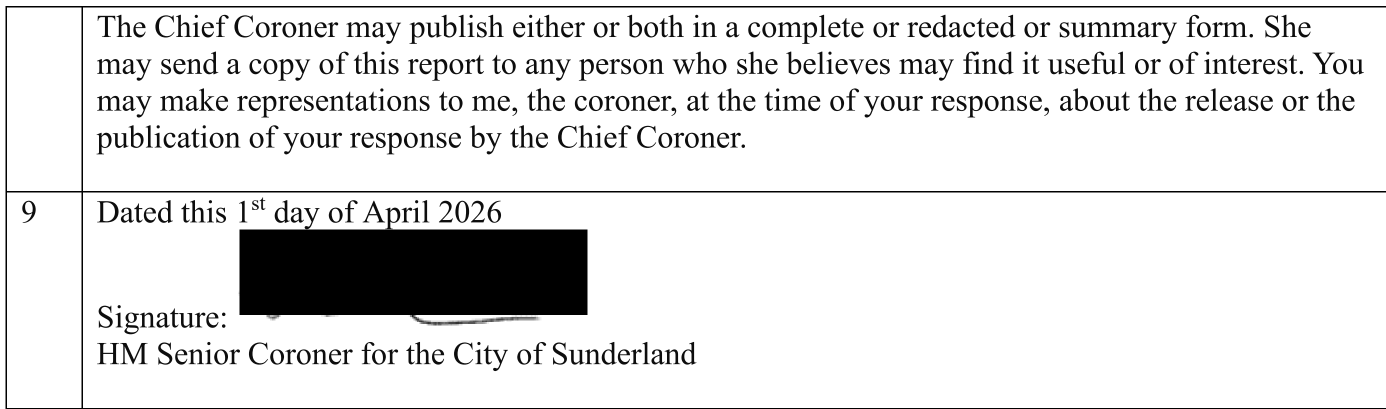
e | web: www.sunderlandcoroner.co.uk

	The **MATTERS OF CONCERN** are: – On the day of her death, Hollie telephoned the North East Ambulance Service NHS Foundation Trust’s 111 service at 05.22 hours. Hollie indicated that she was feeling suicidal and had made her mind up over the last 5 days. She stated that she had a noose around her neck and was about to jump. She added that she did not need an ambulance but needed someone to cut her down. Later in the call she said that she would get herself down. The call handler confirmed that an ambulance was in place. Hollie then referred to having a team involved with her but that whilst it was helping it didn’t change the situation. The call handler reassured Hollie that help was in place for her and confirmed that the door to the property was open. The call handler then said, “I can let you go now that I’ve got that help in place, is that alright?” Hollie said thank you and, after being told to ring back if her condition got worse or had new symptoms, Hollie ended the call. The evidence revealed that the call handler was following the national NHS pathways system and Hollie was considered as requiring a category 3 response in accordance with the pathway. This was correctly upgraded by a clinician following a review. The first ambulance crew arrived at Hollie’s location at 06.17 and she could not be revived. Hollie’s call to the service had ended at 05.31 but she did not respond to attempts by a clinician to call her back at 05.40, 05.43 and 05.45. I am concerned that the evidence revealed that the national NHS pathways telephone triage system provides no guidance to health advisers dealing with such calls about whether to maintain telephone contact with a patient who is clearly expressing suicidal intent and, if maintaining contact, how to do so to ameliorate a risk of that patient ending their own life. Hollie made it clear she had a noose around her neck and was going to jump. I shall be glad to be told of any learning arising from his death and timescales and results of your review.
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 27th May 2026. 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: - • Hollie’s mother • Hollie’s father • Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and their Solicitors • North East Ambulance Service NHS Foundation Trust and their Solicitors • Care Quality Commission I am also under a duty to send the Chief Coroner and all interested persons, who in my opinion should receive it, a copy of your response.



	The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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	Dated this 1st day of April 2026 Signature: HM Senior Coroner for the City of Sunderland