REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive, Somerset Partnership NHS Foundation Trust
1	**CORONER** I am Nicholas Leslie Rheinberg assistant coroner, for the coroner area of Somerset
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 19th August 2019 an investigation was opened into the death of Cariss Lucy Stone. The investigation concluded at the end of the inquest on 9th April 2024. The conclusion of the inquest was that Cariss Lucy Stone died as a result of 1(a) hypoxic brain injury due to 1|(b) cardiac arrest due to 1(c) asphyxia due to pressure to the neck. The conclusion of the jury was that "Cariss Lucy Stone died by accident. Deficiencies in the way that she was observed possibly contributed to her death."
4	**CIRCUMSTANCES OF THE DEATH** Cariss Lucy Stone was detained under the Mental Health Act on Holford Ward in Taunton, a Psychiatric Intensive Care Unit. While detained she self-harmed including multiple occasions of attaching a ligature around her neck and attempting self-strangulation. She was subject to level two observations, universally referred to on the ward as "five minute observations". Staff on the ward were confused as to how often Cariss was required to be observed every hour. During an interval in observations Cariss applied a ligature with fatal effect. The healthcare assistant who found Cariss did not have a ligature cutter.
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 could 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) The Trust's current policy for level two observations requires staff to observe a patient not less than five times an hour at random intervals which shall not be more than 15 minutes apart. A possible training issue was revealed during the inquest. Some members of staff who gave evidence at the hearing and in particular one senior member of staff did not appear to have a clear understanding of the policy and there was concern that agency staff might not receive adequate training (2) In a ward where self-harm including use of a ligature was not uncommon there was concern that members of staff and in particular those involved in carrying out observations on patients were not routinely supplied with ligature cutters.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that your organisation has 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 6th 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely Cariss' family via their legal team. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**10th April 2024** ***Nicholas Leslie Rheinberg*** Assistant Coroner