



Corporate Services Ashbourne Centre Kingsway Site Kingsway DERBY DE22 3LZ

17 June 2024

Ms Sophie Lomas
Assistant Coroner for Derby and Derbyshire
Coroners Court
Town Hall
Rose Hill
Chesterfield
Derbyshire
S40 1LP

Dear Ma'am

Re: Regulation 28 Response: an inquest touching the death of Miriam Stone

May I first begin on behalf of the Trust by conveying my condolences to the family of Miriam, in particular to for her loss. I was updated following the conclusion of the inquest and am sorry that the Jury found issues with the care afforded to Miriam.

I am informed that the Trust confirmed to court on 7 May 2024, following an update from the manager of the bed management team that it was already the custom and practice of the bed management team to not, wherever possible, admit patients during handover times and that this custom and practice was already in operation at the time of the inquest but was due to be placed into the revised policy which had recently been under review. The Trust however acknowledged that due to the presenting risk of a patient it may not always be possible to avoid handover times given the urgent nature of the services the Trust provides.

On Wednesday, 8 May 2024 the Trust sent to your office confirmation that the policy which governs the admission to an acute ward, 'Acute Inpatient Mental Health Services for Adults of Working Age Policy and Procedure', had been amended to include the line detailed below. That correspondence also confirmed that the updated version had been communicated to the bed management team already but would be formally approved on 6 June 2024.

It is best practice for admission during staff shift handover period [7am-7.30 am, 1.45 pm-2.30 pm and 9pm-9.30pm] to be avoided where possible, unless there is an urgent requirement related to immediate patient safety. Learning from incidents has shown that admission during these specific periods leads to an increased risk

relating to transfer of information or allocation of admission actions. Admission times will be co-ordinated by the bed management team, the referring team, the ward staff and the patient and carers involved.

Following the above actions, the formalisation into policy of the custom and practice that already existed has been achieved and I hope that this information reassures you and the family of Miriam that practical steps had already been taken prior to your Regulation 28 Report being sent to the Trust and that the risk you identified has been mitigated against.

