Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Derbyshire Healthcare NHS Trust**
1	**CORONER** I am Sophie LOMAS, Assistant Coroner for the coroner area of Derby and Derbyshire
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 23 February 2022 I commenced an investigation into the death of Miriam STONE aged 41. The investigation concluded at the end of the inquest on 07 May 2024. The medical cause of death was: 1 (a) Hypoxic Brain Injury (b) Cardiac Arrest (c) Ligature Application and Plastic Bag Asphyxia The conclusion of the jury at inquest was a narrative conclusion, namely that: "Miriam carried out the deliberate act of ligating herself [redacted] on 18th February 2022, but in doing so, it is not possible to ascertain her intention." The jury found that a lack of formal risk assessment, a safety assessment which did not include all relevant risks and an inadequate care plan were probable contributing factors in Miriam's death. In addition, the jury found that the level of observations were likely assumed rather than individually assessed and that the level set, namely Level 3 every 15 minutes, was not appropriate.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances are summarised in the findings of the jury: " Miriam Stone died on the 20th February 2022 at the Intensive Care unit at the Hospital. Miriam has a history of various mental health disorders including Emotionally Unstable Personality Disorder, Schizoaffective Disorder, Schizophrenia and Bipolar. Miriam was admitted on numerous occasions and had a long history of self-harm by various methods [redacted]. Miriam was admitted to Hospital on the 15th February 2022 following an overdose. Whilst in hospital, Miriam undertook actions of self-harming and was distressed culminating in

	ligation whilst under 15 minute observations. This resulted in a decision to detain Miriam under Section 2 of the Mental Health Act. Miriam was admitted to the Mental Health Unit on the 17th February 2022 as considered to be a high risk of self-harm or completed suicide and hospital considered a place of safety and assessment. Upon admission Miriam was presenting as calm and not in distress and was being monitored at 15 minute intervals. Miriam was interacting with staff but was not formally assessed by clinical staff and a safety assessment was only partially completed. No documented decision as to levels of observation or suicide risk exists to determine decisions made as to risk. On the morning of the 18th February 2022, 13 minutes after being observed by staff, Miriam was not observable in her bed space and staff recognising the ward toilet door was locked, subsequently found Miriam in the toilet [redacted]. This was swiftly removed and revealed a ligature around Miriam's neck [redacted]. Miriam was taken to hospital where she was intubated and ventilated. Despite treatment, her condition deteriorated and she died on 20th February 2022.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: Miriam was admitted to the mental health unit at approximately 8.30pm. The unit has a staff handover between 9.00pm and 9.30pm. The evidence at inquest was contradictory as to which shift had assumed responsibility for completing admission tasks including risk assessments and care / safety plans. It was recognised that admission shortly before or during shift handover can increase risks relating to the quality of information sharing and the allocation of admission tasks such as assessing the level of observations required. The court heard evidence that whilst efforts would be made to avoid admission during staff handover time this was a local practice rather than part of any formal policy. The court further heard evidence that senior staff considered that avoidance of admission at handover times would be difficult to achieve because there were too many different oranisations who might be requesting admission. This appeared to overlook the fact that it is the bed allocation team based at the trust who are the central point of contact. The current operational policy covering admission procedures (Acute Inpatient Operational Policy) does not mention a need for handover time to be protected, avoiding admission during this time. Without a formal policy on this topic there is a risk that future deaths could occur.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 July 15, 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 [redacted] 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 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 by the Chief Coroner.
9	**Dated: 20/05/2024**  **Sophie LOMAS** **Assistant Coroner for** **Derby and Derbyshire**