H G Mark Bricknell
Senior Coroner
for County of Herefordshire

14th October 2024

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive, Herefordshire and Worcestershire Health and Care NHS Trust.
1	**CORONER** I am Hugh Gregory Mark Bricknell, Senior Coroner for County of Herefordshire
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 18 March 2024 I commenced an investigation into the death of Caroline Ann STAITE. The investigation concluded at the end of the inquest on 30 September 2024. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** A member of public on his way home from work, called at 2339 hrs on 8/3/24 stating he was on the Old Bridge Hereford. They described a body with a backpack, dark clothes, and white trainers in the river and stated the river was flowing fast, that the body had now moved into darkness but was heading towards Victoria foot bridge. Officers were deployed to speak with the informant and additional officers were dispatched to numerous locations along the River Wye. A female body was recovered near the Canary Bridge, Hereford and Paramedic [redacted] pronounced the female deceased at 0241 hours on 9/3/24. The deceased was fully clothed. The deceased had no obvious injuries. A [redacted] contacted the Police saying his sister had not been seen for 24 hours. Her name was Caroline Anne STAITE born 2/6/72. The description matched that of the deceased and subsequent formal identification provided confirmation.
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) The Neighbourhood Mental Health Team should ensure that their procedures are sufficiently robust regarding the sifting of clients for consideration by Mind. (2) The procedure for the return of patients from Mind to the care of the Neighbourhood Mental Health Team should be transparent and encouraged if the Mind worker feels that is appropriate. (3) If so requested by the Mind worker the patient should be returned to the care of the Neighbourhood Mental Health Team and the involvement of the Mind worker discontinued.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, [redacted] 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 9 December 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] CEO Herefordshire Mind. I am also under a duty to send the Chief Coroner a copy of your response. 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	14 October 2024 Signature HG Mark Bricknell, HM Senior Coroner: Herefordshire