REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Chief Executive, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
1	**CORONER** I am Miss Stephanie Haskey, Assistant Coroner, for the Coroner area of Nottinghamshire
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** In November 2014 an Inquest into the death of Emma Carpenter was opened, and it was resumed on 22nd June 2015, concluding on 13th July 2013. A Narrative Conclusion was recorded as follows: "Emma Charlotte Victoria Carpenter died at The Queen's Medical Centre Nottingham as a result of Multi Organ Failure caused by severe Anorexia Nervosa. Her death was contributed to by delay in accessing effective inpatient treatment and physical health monitoring prior to September 2005".
4	**CIRCUMSTANCES OF THE DEATH** Miss Carpenter was treated as an outpatient at the Child and Adolescent Mental Health Services Thorneywood Unit of the Nottinghamshire Healthcare NHS Trust ("the Trust") from February 2004 to November 2006. During this time there was insufficient monitoring of her physical health, and in particular no specialist input by paediatricians or physicians.
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 Trust has now set up a specialist Eating Disorder Service for children and adolescents, and reports that although this service now has good professional links with named paediatricians at Kings Mill Hospital and Queen's Medical Centre, there are no equivalent links with Bassetlaw Hospital.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 8th September 2015 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] Nottinghamshire Healthcare NHS Trust Nottingham University Hospitals NHS Trust Nottingham High School for Girls [redacted] Nottingham Safeguarding Children Board The Care Quality Commission. 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	**[DATE]** 14.7.15 **[SIGNED BY CORONER]** **Stephanie Haskey** [redacted]