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.** Rt Hon Sajid Javid MP, Secretary of State for Health and Social Care **2.** Rt Hon Kit Malthouse MP, Minister for Crime and Policing **3.** [redacted], Chief Executive Officer of NHS England **4.** [redacted], Chair of the National Police Chiefs Council **5.** [redacted], Chief Executive of Yeovil District Hospital NHS Foundation Trust
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 the 3rd December 2019, an investigation was commenced into the death of Felicity Jane Clough, born on the 8th July 1964. The investigation concluded at the end of the Inquest on the 16th November 2021. The Medical Cause of Death was: 1a Hypothermia and excessive use of Tramadol The conclusion of the Inquest was a narrative conclusion that Felicity Jane Clough died as a consequence of a combination of the excessive use of prescribed medication and her exposure to cold weather conditions, in circumstances where she was dressed inappropriately for those conditions and she had not eaten or slept for several days.
4	**CIRCUMSTANCES OF THE DEATH** On the 24th November 2019 the deceased, who was prescribed Tramadol, was taken by the Police and Paramedics to Yeovil District Hospital, Yeovil under the Mental Capacity Act 2005. She arrived there at approximately 1.48am. She was seen by the emergency department team and the psychiatric liaison team and was discharged at 3.57am. She left the hospital on foot wearing leggings and a vest when outside ground and air temperatures were between 7.4 and 9.2 degrees Celsius. She was last seen at approximately 4.00am walking along the pavement on the A37 in the direction of her home address at [redacted] Yetminster, Sherborne. Around 1pm on the 25th

	November 2019 she was found in a collapsed and unresponsive condition in a field at Darvole Farm, East Coker, Yeovil, Somerset.
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. During the inquest evidence was heard that: i. There are different systems used by healthcare trusts across England and Wales for holding patients records and information. Each trust has their own system which other trusts do not have access to. This means that vital and important information recorded on one trust database may not be available to a different trust who is caring for a patient. This applies to both physical and mental healthcare trusts. The lack of access to this information could prove to be life threatening. ii. At the time of her death Miss Clough was under the care of Dorset Healthcare University NHS Foundation Trust (DHUFT) who provide mental health services across Dorset. On the 24th November 2019 she was taken to Yeovil District Hospital, Yeovil where she was assessed by a mental health professional from Somerset NHS Foundation Trust. Somerset NHS Foundation Trust at the time did not have access to the records held by DHUFT. iii. Following the death of Miss Clough, agreements have been put in place that DHUFT will share their records with those at Somerset NHS Foundation Trust. Discussions remain ongoing regarding Somerset NHS Foundation Trust sharing their records with DHUFT, but this is likely to happen going forward. iv. Allowing access to records across the NHS system on a national basis will provide better care to patients and prevent future deaths. This would mean that if a patient was visiting an area away from their home address and usual care providers, those caring for them in their visiting area would have access to the full medical history to inform their treatment and potentially prevent future deaths. v. In addition, each Police force across England and Wales uses a variety of databases and record management systems. There is a Police National Database (PND) which was created to collect data in a uniformed manner for crime, intelligence, custody, child abuse and domestic abuse from every force across the UK, however there is no means to share information automatically across Police forces regarding concerns raised about a person's welfare or health. To do this would require officers from one force to contact another force which requires knowledge of the contact in the first place. vi. On 24th November 2019 Dorset Police officers attended upon Miss

Clough at her home address in Dorset and transferred her to Yeovil District Hospital in Somerset under the Mental Capacity Act 2005. A short time later she was discharged and left the hospital on foot to walk home. Following discharge she came into contact with Avon and Somerset Police officers who were not aware of her previous contact with Dorset Police or her admission to hospital. Evidence was given that had they been aware of this contact, it could have changed the way they checked upon Miss Clough that evening.

vii. Greater sharing of information therefore between Police forces in England and Wales regarding the welfare of those who come into contact with the Police could prevent future deaths.

viii. Evidence was given that it would be wholly beneficial, both within the Police and the NHS, if systems were able to talk to one another. This would allow a wider understanding of the risk factors associated with an individual and it could prevent a future death if there was more information known about a person's vulnerability or risk. It would be beneficial to have a national system where healthcare trusts could access each other's records and another national system where Police Forces can access information re health and wellbeing.

ix. At the Inquest evidence was also given that when a person is taken to Yeovil District Hospital via ambulance, the paramedics transfer their records electronically to the hospital. These records are sent at the point that the receiving hospital is entered onto the paramedic system. The information is therefore usually available prior to the attendance of the patient and certainly upon the arrival of the patient at the Emergency Department of a hospital.

x. Evidence was given that these records are not always reviewed and that critical and vital information regarding the person's presentation or history could be contained within this paramedic record. If this is not reviewed and therefore missed, it could lead to a future death.

2. I have concerns with regard to the following:

i. There could be future deaths nationally due to the lack of accessibility to records held by different healthcare trusts. I would request consideration is given to the sharing of records between healthcare trusts.

ii. I have concerns that future deaths could occur due to the lack of access to information held on individual Police force systems by other forces, especially neighbouring forces who may both have contact with individuals. Whilst I understand there is some work being done on a regional basis to address this, I would request that the issue is considered nationally as to how information held on all Police systems, not just the Police National Database, can be shared to assist in the management and assessment of individuals and the risk they pose to themselves or others.

iii. I have concerns that future deaths could occur at Yeovil District hospital due to the missing of vital information within the pre

	admission documentation due to the fact the staff within the Emergency Department at Yeovil District Hospital are not always accessing admission documentation, especially the paramedic records when a person is brought into the Accident and Emergency department. I request that consideration is given to issuing further guidance to remind staff of the need to review this documentation or amending the current policy in place.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 21st January 2022. 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: (1) Broudie Jackson Canter Solicitors on behalf of Felicity's family (2) DAC [redacted], of behalf of Dorset Healthcare University NHS Foundation Trust. (3) [redacted] on behalf of the Yeovil District Hospital NHS Foundation Trust and Somerset NHS Foundation Trust (4) Dorset Police (5) Avon and Somerset Police 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	**Dated** **26th November 2021**	**Signed** **Rachael C Griffin**