Department of Health & Social Care

[redacted]
Minister of State for Care and Mental Health
39 Victoria Street
London
SW1H 0EU

[redacted]

Ms Rachael Griffin
Coroner's Office for the County of Dorset
Town Hall
Bournemouth
Dorset
BH2 6DY

23 May 2022

Dear Ms Griffin,

Thank you for your letter of 26 November 2021 about the death of Felicity Clough. I am replying as Minister with responsibility for Care and Mental Health, and am grateful for the additional time allowed.

Firstly, I would like to say how deeply sorry I was to read the circumstances of Felicity Clough's death and I offer my most heartfelt condolences to her family. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention. We must do all we can to ensure such failings in the health care system do not occur again.

With regard to your concerns about the lack of accessibility to records within the Yeovil District Hospital Trust, my officials have made me aware that the Trust has taken immediate action and implemented measures in order to mitigate the risk of staff not accessing pre-hospital information. In addition, the Care Quality Commission, the regulator, has informed the Department that they are in receipt of the Trust's action plan which is noted to be comprehensive.

To share information lawfully, NHS organisations must comply with the principles set out in the General Data Protection Regulations, and the common law duty of confidence. They should also apply the Caldicott Principles which have been established by the National Data Guardian for Health and Social Care to govern how data is shared by health and care organisations.

It is my understanding that Ms Clough was taken to hospital by the Police under the Mental Capacity Act 2005 (MCA). The MCA's Code of Practice allows for information about someone who lacks the relevant capacity to be shared where it is in the best interests of the patient or the public to do so[1].

[1] See paragraphs 16.19-16.25;
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf

For those patients subject to the Mental Health Act 1983, information sharing between professionals can contribute to and support the care and treatment of patients and help to protect people from harm, including information sharing as part of the care programme approach. Chapter 10 of the Mental Health Act 1983 Code of Practice[2] sets out the circumstances in which it may be permissible to share patient information. The Code makes clear that, before considering such disclosure of confidential patient information, the individual's consent should normally be sought. If a person lacks the capacity to consent to the disclosure, it may be acceptable and appropriate to disclose the information in the person's best interests.

Healthcare professionals should use their professional judgement to determine what is in the patient's best interest. This should include consultation with colleagues, and the organisation's Caldicott Guardian, and should take into account the patient's previously expressed wishes and views. All NHS organisations, as part of their information governance arrangements, are required to have in place Caldicott Guardians who have responsibilities to safeguard and govern the use of patient information and can provide advice in circumstances where there may be uncertainty about disclosure.

Difficulties within the sharing of information between different parts of the health and care systems is a well recognised issue. Currently, NHS England's Shared Care Records initiative is seeking to rectify this. The focus of the programme is on sharing of information within the boundaries of the Integrated Care Systems – in this case within Dorset and Somerset. So far, 41 of the 42 Integrated Care Systems have already implemented a basic solution. Furthermore, the NHS Priorities and Operational Planning Guidance for 2022/23 set out a commitment to get these systems to work within regions by the end of 2022/23 and nationally no later than 2023/24[3].

The NHS Long Term Plan Implementation Framework[4] makes several commitments to improve information sharing. By 2024, all secondary care providers should be fully digitised and integrated with other parts of the health and care system, for example, through a local health and care record platform. Shared care records ensure that information and care plans are available across health and social care to support planning, better risk management and ensure care is more joined up and delivered around an individual's needs.

The exchange of information between police forces is not a matter the Department can comment on. However, the importance of being able to have insight into the health status of an individual when determining a police response is well recognised,

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[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

[3] Further details of the Dorset Care Record are at https://www.dorsetccg.nhs.uk/project/dorset-care-record/ and the Somerset Integrated Care Record at https://www.somersetccg.nhs.uk/about-us/digital-projects/sider/

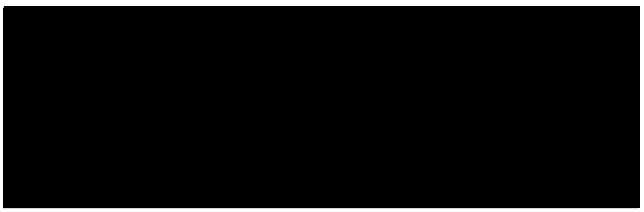
[4] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/06/long-term-plan-implementation-framework-v1.pdf

although providing the police with direct access to personal confidential health information is a highly sensitive matter and one where Caldicott Guardians may advise.

Finally, it is concerning to hear about the circumstances in which Ms Clough left the A&E Department. Under the hospital discharge guidance, no person should be discharged until it is safe to do so.

The NHS Long Term Plan committed to introducing mental health nurses in ambulance control rooms and building mental health competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a mental health crisis by 2023/24. Mental health liaison services will also be available in all acute hospital A&E departments (70% will be at 'core 24' standards in 2023/24, expanding to 100% thereafter. It is vital that these actions prevent such a tragedy from happening in the future.

I hope this response is helpful.



Home Office

Rt Hon Kit Malthouse MP
Minister of State for Crime, Policing and Probation
2 Marsham Street
London SW1P 4DF
[redacted]

Ms Rachel Griffin – Dorset Senior Coroner

By email only
[redacted]

[redacted]

13 February 2022

Re: MIN/0212540/21 - REG 28 notice: Felicity Jane CLOUGH (ref: 1631166):

I write in response to your letter dated 26th November 2021 and the enclosed Regulation 28 – Report to Prevent Future Deaths which relate to the tragic death of Miss Felicity Jane Clough.

Firstly, please express my sincerest condolences to Miss Clough's family.

Upon receipt of your report, I requested the National Police Chiefs' Council and the Home Office Police and Public Protection Technology department to review the circumstances surrounding the case and to make any recommendations they consider necessary to reduce the risk of such an incident occurring in the future.

The review was performed by a joint Task and Finish Group comprising a team of subject matter experts for the Police National Computer (PNC) and the Police National Database (PND) which are the two current national policing data services shared across all UK Police Forces. This team was jointly led by Deputy Chief Constable (DCC) [redacted] who is the NPCC Lead for PNC and by [redacted], the Home Office Director of the National Law Enforcement Data Portfolio.

The review was performed against the findings set out in the Regulation 28 report referred to above and DCC [redacted] has provided a detailed response and conclusions in his attached letter.

Following the conclusion of the review of detail related to this incident, the following recommendations were made:

Action 1: For Operational Police Officers/Police Staff to ensure greater utilisation of the Police National Database (PND). This would include encouraging uploading safeguarding information to PND, to ensure it is accessible country wide, as well as Officers asking for the PND to be searched against any vulnerable individuals when encountering seemingly vulnerable persons.

Action Owner: DSU [redacted] - PND Staff Officer (on behalf of NPCC PND Lead).

Action 2: For Operational Police Officers/Police Staff to actively consider making referrals into the Multi-Agency Safeguarding Hubs and/or Control Room Triage services, which should in turn record any relevant information determined through these collaborated units onto PND. This will ensure greater information sharing around vulnerability across all UK Police Forces.

Action Owner: NPCC Safeguarding Lead

Action 3: For Chief Officers and Home Office Officials involved in the design and delivery of the PND transformation, to consider the development of a safeguarding capability and how it can add greater operational effectiveness across safeguarding agencies/authorities.

Action Owners: DCC [redacted] (NPCC PNC Lead), Mr [redacted] (Home Office Director: NLEDP).

In respect of Actions 1 and 2, the team anticipate providing a further update to you by end of March 2022. In respect of Action 3, the team will provide an update on the progress in six months' time.

I thank you kindly for your patience and support in this matter while the team reviewed the circumstances leading to this tragic incident and hope that the actions resulting from this review will help prevent similar incidents from occurring in the future.

[redacted]

Rt Hon Kit Malthouse MP
Minister of State for Crime, Policing and Probation

National Medical Director and Interim Chief
Executive of NHS Improvement
NHS England & NHS Improvement
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Ms Rachel Griffin
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Town Hall
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[redacted]

29th March 2022

Dear Ms Griffin

Re: Regulation 28 Report to Prevent Future Deaths – Felicity Jane Clough who died on 25 November 2019.

Thank you for your Regulation 28 Report (hereinafter 'Report') dated 26 November 2021 concerning the death of Felicity Clough on 25 November 2019. Firstly, I would like to express my deep condolences to Felicity's family.

I note the recent inquest concluded Felicity Clough's death was a result of:

- 1a Hypothermia and excessive Tramadol use

Following the inquest you raised concerns in your Report to NHS England regarding:

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

- 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 have 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 on all Police systems, not just the Police National Database, can be shared to assist in management and assessment of individuals and the risk they pose to themselves and others.

- 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 Emergency department. I request that consideration is given to issuing future guidance to remind staff of the need to review this documentation or amending the current policy on place.

The difficulty of sharing information between different parts of the health and care systems is well recognised.

NHS England have a programme of work – the Shared Care Records initiative – which is seeking to rectify this.

The initial focus is on sharing within the boundaries of the Integrated Care Systems – in this case within Dorset and within Somerset – and 41 of the 42 Integrated Care Systems have already implemented a basic solution. There is a commitment to get these to interwork and this was set out in the most recent NHS Priorities and Operational Planning Guidance for 2022/23. The intention is for this to work regionally by the end of 2022/23 and nationally no later than 2023/24
Details of the Dorset Care Record are at https://www.dorsetccg.nhs.uk/project/dorset-care-record/ and the Somerset Integrated Care Record at https://www.somersetccg.nhs.uk/about-us/digital-projects/sider/
The exchange of information between police forces is not a matter NHS England can comment on.

However, the importance of being able to have insight into the health status of an individual when determining a police response is well recognised, although providing the police with direct access to personal confidential health information is a highly sensitive matter.

In some forces a registered health professional works closely with the police control centre in order to identify where the provision of such health information is – in their professional view - considered justifiable and in the person's best interest. However, access to such information is also subject to the limitations expressed in recommendation 2i and needs to be addressed to ensure that such attached professionals have ready access when they consider it justifiable.

Regarding your concerns around future deaths at Yeovil District hospital due to the missing of vital information within the pre admission documentation because 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 Emergency department. I have read the Trust's reply and consider concern answered and therefore does not need national response.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information. I do hope the above information goes someway to explain the steps being taken by NHSEI to address these already recognised issues.

Yours sincerely,

[redacted]

[redacted]
National Medical Director

National Police Chiefs' Council

Rachael Griffin
Her Majesty's Senior Coroner
The Coroner's Office for the County of Dorset,
Bournemouth Town Hall,
Bournemouth,
BH2 6DY

By email only: [redacted]
Your Ref: 1631166

Date: 2nd February 2022

Dear Mrs Griffin,

Regulation 28 Report – Ms Felicity Jane Clough

I am writing to you on behalf of the National Police Chiefs Council (NPCC) in my capacity as Chair of NPCC Information Management and Operational Requirements Coordination Committee (IMORCC), in relation to paragraph 7, Schedule 5 of the Coroners and Justice Act 2009, and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, and to the prevention of future deaths report sent via email to the NPCC dated 29th November 2021.

The notice sets out concerns that arose from the information received during the inquest into the death of Ms Felicity Clough which occurred in November 2019. I am very sorry to read of the circumstances of Felicity's death. My sympathies are with her family and friends, and I share your commitment to addressing the issues that contributed to her untimely loss.

The notice sets out the following principal concerns in relation to Policing:

1) 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 officer 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 known 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.

2) 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 that 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.

I will look to address the concerns you have raised as follows:

Policing recognises the challenges identified in the concerns you have raised and are working hard to address the difficulties of siloed information within forces as well as the importance of information sharing across other agencies to help protect the public and reduce the risk of harm. Balancing the needs of individuals and privacy rights.

The National Police Chiefs Council (NPCC) Information Management and Operational Coordination Committee (IMORCC), aims to ensure that information is shared to reduce harm, make the public safe and reduce crime. The committee oversees several working groups that will deliver national information sharing agreements, provide data that is needed from national systems and on mobile devices and share data with partners where appropriate. IMORCC has recently set up a Data Board

that is chaired by the Metropolitan Police Service Director of Data. This has seen data leads from across Policing, Home Office, PDS and National Crime Agency come together to specifically deal with issues that relate to the quality, management and use of data to improve the service we provide across the policing environment.

Each force is responsible for their own budget and how they allocate this will depend on their individual needs. This is reflected in their ICT infrastructure with regards to systems and staffing which equates to the capabilities across each force being significantly different. This can also be seen in the Records Management Systems (RMS) each force holds and as such there are several different suppliers and systems in use throughout the country that do not communicate easily with each other. Each Chief Constable is the Data Controller for their force and has ultimate responsibility for the management and use of data and information as defined by the Data Protection Act 2018.

The policing Digital, Data and Technology Strategy 2020-2030 sets out ambitions and priorities that are pertinent to this matter in 'addressing harm' and 'embedding a whole system approach' to deliver enablers such as 'Data', 'Modernised Core Technology', and 'Connected Technology'.

The concern documented within **viii** outlines the need for police to be able to access NHS systems. The difficulties of achieving this across policing alone have been highlighted above and until we have this capability internally, we would not be able to link all the NHS and policing systems quickly. That said, some forces have tried to bridge the data gap between the police and NHS through the introduction of medical teams into their control rooms. These NHS staff members have direct access to NHS and police systems, and they review incidents where mental health, harm and vulnerabilities are highlighted. Even though this is not fully automated through system integration, this demonstrates police are trying to bridge that gap and it allows officers access to real-time information and intelligence to aid informed decision making. For those vulnerable individuals already known to policing, the Multi Agency Safeguarding Hubs are a useful conduit for sharing information across partner agencies, albeit this is a local function.

The national policing ambition is to deliver what is described in **2) ii**; an ability 'for information held on **all** Police Systems to be shared to assist in the management and assessment of individuals and the risk they pose to themselves or others' as well as a process by which Police Forces can access information re health and wellbeing. Unfortunately, the complexity involved in this and the need to unpick legacy databases and systems means that to deliver this ambition will take significant time and investment and some thought would need to be given to the ethics and governance of such an approach. The National Law Enforcement Data Programme (NLEDP) was launched in 2016 by the Home Office, with the initial intention of providing a platform that replaced and enhanced the capabilities of the Police National Computer (PNC) and the Police National Database (PND). This was to be the platform that will enable this greater sharing of information. To illustrate the complexities, this programme was due to be completed in 2020 but is not yet in a position to deliver the expected

services. PND replacement is not currently part of the scope of the programme, but a 5-year plan is being implemented by the Home Office to commence the work shortly. This programme of work includes a review of what data is held locally and what should be held on the national system.

The Police Digital Service (PDS) was created in April 2021, with the ambition of delivering the Digital, Data and Technology Strategy 2020-2030. Part of the PDS is the creation of a new NPCC National Data Office and proposed Data Strategy (LEARN), that will look at the opportunities for better use of data including that of other agencies. Work has already commenced to try to address data issues to enable sharing of each forces RMS data across policing.

The suggestion of a health & well-being database shared between the NHS trusts and policing is quite a significant task, technically, lawfully and ethically, and until policing has achieved its own strategic data aims, this is unachievable without a significant national investment and a comprehensive programme of work being commissioned across all partners. The work being carried out to achieve the strategy should go some way to demonstrate the importance that policing places its responsibility to enable more effective data sharing between forces.

This is a complex issue and I hope that the information that has been provided goes some way to reassure you that the matters of concern you have raised are being considered and that we are working with our Home Office and emergency services colleagues to deliver on the improvements that have been highlighted.

Yours sincerely,

[redacted]

[redacted]

Chief Constable, Durham Constabulary

National Policing Lead for the Information Management & Operational Requirements Coordination Committee (IMORCC)

Yeovil Hospital Healthcare

NHS

20 January 2022

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Ms R Griffin
Senior Coroner
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Bournemouth Town Hall,
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BH2 6DY

email: [redacted]

Dear Ms Griffin,

Re : Felicity Jane Clough

I am writing in response to the Coroner's report to prevent future deaths following from the inquest into the death of Felicity Jane Clough.

I can confirm that the Emergency Department at Yeovil District Hospital has put measures in place that will mitigate the risk of staff not accessing pre-hospital information for those patients that attend the department and in particular those brought in by ambulance. I have included a copy of the action log regarding this issue with this correspondence.

In summary, whilst we would aspire to having a fully automated system allowing access to the ambulance records and other pre-hospital information through the hospital's Electronic Health Care Record (Trakcare), this is not yet possible. However, we have been able to identify and put in place an interim measure which gives the same outcome in terms of making the pre-hospital information available to all staff in an electronic format stored within our existing system.

The immediate measure of converting the pre-hospital information available on other organisations' electronic systems into a PDF document and saving within our Trakcare system was introduced within the Emergency Department on 6 January 2022. This allows easy access to important information. We have shared the patient story and learning from this tragic incident with the Emergency Department team, together with the expectation of considering ambulance records as part of their initial assessment. Along with ongoing education, this will help to improve patient safety by ensuring our clinicians access all of the relevant clinical details required to effectively treat their patients.

I hope that this has assured you that appropriate actions have been taken in respect of the issues raised in your regulation 28 report. Please let me know if you require any further information.

Yours sincerely

[redacted]

[redacted]
Chief Executive

Enclosures:
Action Log