	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive Officer NHS England** 2. **Chief Executive Officer Surrey County Council** 3. **Chief Constable Surrey Police** 4. **Chief Executive Officer Surrey and Borders Partnership NHS Foundation Trust**
1	**CORONER** I am Darren Stewart OBE, Assistant Coroner, for the Coroner Area of Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 8th July 2021 I commenced an investigation into the death of Barbara Ann WOODMAN. The investigation concluded at the end of the inquest on 18th October 2022. The inquest was heard without a Jury. Ms. Woodman died of: 1a. Paracetamol, Codeine and Amlodipine Toxicity I returned the following narrative conclusion: Barbara Ann WOODMAN was admitted to the Abraham Cowley Unit under section on the 4th of March 2021 following an overdose on the 23rd of February 2021 which resulted in her emergency admission to Epsom General Hospital. She was initially guarded and did not engage with Spenser Ward staff seeking to provide her with care and treatment, although this subsequently improved during her period of inpatient care. The initial diagnosis of depression which had led to her section was determined inaccurate and a substitute diagnosis of personality disorder agreed, although additional work following her discharge was to be undertaken to identify the correct subcategory of personality disorder. Ms. WOODMAN was discharged from section on the 18th of March 2021 and agreed to remain at the Abraham Cowley Unit as an inpatient for a further period of assessment. On the 25th of March 2021 she was assessed as fit for discharge to the community under the care of the Community Mental Health Team. A telephone conversation between Ms. WOOMAN and her Care Coordinator occurred on the 26th of March 2021. During this call the Care Coordinator assessed Ms. WOODMAN as not posing an escalated risk to herself. There was an interaction between Ms. WOODMAN and the Police on the 27th of March 2021 when police attended at her residence. No concerns were identified in relation to her risk to self except for the possible use of alcohol. A SCARF Report was raised by Police on the 27th of March 2021 in relation to this contact. It was

	passed to the Community Mental Health Team by Surrey County Council Adult Social Services on the 29th of March 2021. The SCARF Report was considered by Ms. WOODMAN's Care Coordinator on the morning of the 31st of March 2021. After several failed attempts to contact Ms. WOODMAN for a pre-arranged call on the 31st of March 2021, Ms. WOODMAN's Care Coordinator visited her residence at around 16:30 hours to ascertain her whereabouts, posting a note through her letterbox when she could not contact Ms. WOODMAN. Following discussion within the Community Mental Health Team, Police were notified of a concern for Ms. WOODMAN's welfare at 18:00 hours on the 31st of March 2021. Police attended Ms. WOODMAN's residence at around 19:20 hours and having forced entry discovered Ms. WOODMAN deceased. No notes or other evidence indicating that Ms. WOODMAN had intended to take her life were found. Post-mortem examination of Ms. WOODMAN's body determined that she had died from Paracetamol, Codeine and Amlodipine toxicity. She had also consumed alcohol. It is not clear why Ms. WOODMAN consumed a fatal quantity of these drugs, and her death was drug and alcohol related.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are recorded in the Narrative Conclusion.
5	**<u>CORONER'S CONCERNS</u>** Although I found there was no causal link between any act or omission on behalf of those involved in the care of Ms. Woodman, either from a mental health perspective, or by any other state agent, several matters have given me cause for concern. The **MATTERS OF CONCERN** are as follows: a. [redacted] evidence is that on several occasions during Ms. Woodman's inpatient admission to Spenser Ward he was in communication with her and of which treating clinicians were aware. On at least one of those occasions [redacted] spoke with Spenser Ward staff. I noted that Ms. Woodman had not given consent for staff to contact [redacted] concerning her treatment. Notwithstanding this, I found that there were missed opportunities to gather important collateral history from [redacted]; Ms. Woodman's partner and who knew her well in the lead up to her admission. It would seem that staff speaking with [redacted] on these occasions failed to think laterally or innovatively as to how to collect important, relevant collateral history whilst still respecting Ms. Woodman's wish that her condition not be discussed with [redacted]. The ability of mental health clinicians to gain a complete picture of Ms. Woodman's medical history was hampered by the fact that the information management systems holding these records at her GP practice was not accessible to secondary mental health services. This resulted in gaps in information available to mental health clinicians which was not necessarily filled by measures taken by secondary mental health services to gather collateral information from the family and Ms. Woodman herself.

b. The handling of the Single Combined Assessment of Risk Form (SCARF) within the Community Mental Health Team (CMHT) on 29th of March 2021. The SCARF was categorised Amber and had been received by SABP from the Police via Surrey County Council Adult Social Services. It concerned a patient on the CMHT's books. Several witnesses gave evidence that best practice would involve the family of Ms. Woodman being contacted when the SCARF was received and considered. This did not occur. The failure to consider the SCARF in a more timely manner or refer the details to Ms. Woodman's family is of concern; both in relation to timeliness of consideration and actions on receipt of the SCARF.

c. The care planning and recording of care plans within Ms. Woodman's notes raises a further area of concern. Questions exist as to the adequacy of the manner in which Ms. Woodman's care plan was recorded. It required anyone wishing to understand the care plan for Ms. Woodman to consult her SystmOne medical record and read the detailed note recorded following the Discharge CPA meeting on the 25th of March 2021, extrapolating from this to deduce the broad care plan. There was, it would seem, no single document that drew together multiple inputs from either MDT meetings (where risk had been considered), or aspects of care and crisis contingency planning (such that this had been considered). The result was a failure to present a holistic view of how Ms. Woodman's care and risk would be managed in the community. Although not causative of the death and I noted [redacted]' very clear expert evidence that had a Crisis and Contingency Management Plan (CCMP) been in place it would have been unlikely to have averted the death, the failure to produce such a clear plan in accordance with Trust policies is a concern.

d. Multiple witnesses observed that there is frequent tension between inpatient staff and the CMHT in the context of decisions relating to the discharge of inpatients. I note the explanations provided as to why such tension exists given the role of each team. However, in the context of Ms. Woodman's care, these tensions led to gaps and breakdowns in communication between inpatient and CMHT with respect to diagnosis and formulation of both the care plan and CCMP.

I received further evidence in writing from the Interested Persons' subsequent to the completion of the Inquest in relation to these concerns.

This evidence included a response from Surrey and Borders Partnership NHS Foundation Trust (SABP) concerning the measures which have been put in place to address the failures identified during the course of the Inquest.

These measures included:

1. The introduction of a clear discharge pathway (including risk assessment and care planning), with a clear role for the discharge coordinator and strengthening of the lead nurse involvement.

2. The introduction of a discrete role to liaise and engage with family (including where this may need to come from different family members) to collect collateral information relating to a patient.

3. The use of a mental health services multi-disciplinary team (MDT) to identify where possible gaps in patients previous medical history.

	4. The introduction of measures to increase collaboration between in-patient and community mental health services. 5. The use of an SABP duty team member to monitor SCARF messages left in group e-mail boxes out of hours. I was satisfied that these measures addressed the concerns in relation to sub-paragraphs c & d above. I was also satisfied that the measures introduced by SABP in relation to sub-paragraphs a & b have addressed my concerns in relation to SABP's involvement in those areas. **However, I remained concerned in relation to the matters identified at sub-paragraphs a & b (above).** 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: There is a lack of a unified record keeping system which allows the effective sharing of patient information between different components of the NHS, including primary and secondary care providers. This results in circumstances where important, relevant information for the treatment of patients is not available to treating clinicians. The use of the SCARF process during out of hours to provide timely and effective passage of information in relation to concerns for vulnerable persons in the community.
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 16th February 2024. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting outthe 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 namely: a. Family of Barbara Ann WOODMAN i. [redacted] (Son) ii. [redacted] (Daughter) iii. [redacted] (partner of Ms. WOODMAN) b. Surrey and Borders Partnership NHS Foundation Trust (SABP) c. Epsom General Hospital (EGH) d. Surrey County Council Adult Social Care (SCC ASC) 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 other person who I believe may find ituseful 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 usefulor 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.
9	**22nd December 2023** **Darren Stewart OBE**