	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive Officer, NHS England** 2. **Chief Constable Hampshire and Isle of Wight Constabulary**
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 26th October 2021 I commenced an investigation into the death of Meghan Irene CHRISMAS. The investigation concluded at the end of the inquest on 24th April 2023. The inquest was heard with a Jury. Mrs. CHRISMAS died of: 1a: Hypoxic Brain Injury 1b: Cardiac Arrest (Resuscitated) 1c: Hanging The jury returned the following narrative conclusion: Narrative conclusion On 18th February 2021, Mrs. CHRISMAS had a face-to-face appointment with her GP, after which 50mg of the anti-depressant Sertraline was prescribed. Mrs. CHRISMAS suffered a panic attack on 4th July 2021 whilst out with friends for which an ambulance was called. On 7th July 2021, Mrs. CHRISMAS was referred to a private psychiatrist who admitted her voluntarily to the Priory, Roehampton after a new patient assessment. Mrs. CHRISMAS had two consultations with the private psychiatrist before electing to discharge herself from the Priory on 16th July 2021. Following this discharge, Mrs. CHRISMAS continued to meet with the private psychiatrist and received prescriptions from both the private psychiatrist and her GP, meaning that Mrs. CHRISMAS had access to double prescriptions. Mrs. CHRISMAS also commenced Eye Movement Desensitization and Reprocessing (EMDR) Therapy on 9th August 2021 with a separate private mental health practitioner. On 1st October 2021, Mrs. CHRISMAS impulsively attempted suicide by overdose and was admitted to Royal Surrey Hospital on the following day. Mrs. CHRISMAS was offered further psychiatric treatment through the NHS at this time, which she declined in favour of continuing with her private treatments. On 4th October 2021, Mrs. CHRISMAS's GP received a letter from Surrey and Borders Partnership's psychiatric liaison service concerning her attendance the previous day. This letter was passed on to neither the private psychiatrist nor the EMDR therapist who were treating Mrs. CHRISMAS. Healthcare professionals treating Mrs. CHRISMAS

	placed significant reliance on the perception that she would be open and honest in her communication with them. Following concerns expressed to Mrs. CHRISMAS's GP by her husband, on 12th October 2021, the GP made an urgent referral to NHS Mental Health Services, which was ultimately rejected on the basis that Mrs. CHRISMAS had capacity and had not provided consent to be referred. On 18th October 2021, Mrs. CHRISMAS had an outpatient appointment with her private psychiatrist who reported that Mrs. CHRISMAS was progressing well. After checking into the Premier Inn, Guildford, Mrs. CHRISMAS expressed in a WhatsApp message to her husband that she planned to hang herself. Shortly thereafter, her husband called 999 to report his concerns. At 16:54, Mrs. CHRISMAS contacted Surrey Police to explain that she was fine and in Guildford, although she gave no further details with respect to her location. The incident regarding Mrs. CHRISMAS was initially logged as a Grade 1 Missing Person; however, according to the Hampshire Police control room logs there appears to have been some confusion with respect to risk status. Police officers acted under the impression that the incident was indeed high-risk, but the log describes the risk status as low. On the basis of this information, the handler in the control room decided to communicate with Surrey Police via email rather than by telephone at 17:18, which was inappropriate in light of the reality of the incident. It could not be concluded that this shortcoming significantly shortened the life of Mrs. CHRISMAS. By 18:15, there had been no response from Surrey Police, at which point the handler communicated via telephone. Police officers arrived at [redacted], Guildford at 18:37 and sought access to the room in which Mrs. CHRISMAS was staying; however they found the room to be barricaded. Upon gaining access to the room, officers found Mrs. CHRISMAS suspended [redacted]. Attempts were made to resuscitate Mrs. CHRISMAS, resulting in the restarting of her heartbeat. After resuscitation, Mrs. CHRISMAS was transported to Royal Surrey County Hospital where she died two days later on 20th October 2021 from a Hypoxic Brain Injury. Meghan Irene CHRISMAS took her own life whilst suffering from the diagnosed illnesses of Generalised Anxiety Disorder, Depression, Attention Deficit Hyperactivity Disorder and Complex Post Traumatic Stress Disorder.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are recorded in the Jury's Narrative Conclusion.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. The concerns raised were as follows: a. Passage of information between NHS and private healthcare providers. At a time where pressures on the NHS exist, particularly for mental health services, it is of concern that measures which could alleviate this pressure (where someone sources private care) do not exist. There is little or no policy, guidance or other effective arrangements to share important clinical information about patients between private and public healthcare sectors. b. The handling of the incident involving Mrs. CHRISMAS in Hampshire Constabulary's Force Control Room which resulted in a hour delay in determining that an important communication (being a request for assistance) had not been received by a neighbouring force. This raises concerns as to the effectiveness in the supervision of operators handling the calls and the presence of redundancies or safeguards to detect such circumstances sooner to avoid repetition. I received further evidence orally and in writing from the Interested Persons' subsequent to the completion of the Inquest in relation to these concerns. This evidence included responses from Surrey and Borders Partnership NHS Foundation Trust (SABP), The Priory Hospital, [redacted] concerning the measures which have been put in place to address the concerns identified during the course of the Inquest with respect to sub-paragraph a. (above). I was satisfied that these measures addressed the concerns in relation to each of those Interested Persons. In addition, I received evidence from Hampshire Constabulary concerning the measures which have been put in place to address the concerns identified during the course of the Inquest as outlined at sub-paragraph b. (above). These measures included: a. Revision of training provided and the introduction of additional training for supervisors and control room staff. b. Implementation of National Policy concerning Missing Persons, including documentation to assist in control room responses to similar circumstances. c. Revision of the recording of risk assessment measurements on the computer aided dispatch record (CAD) system. It was further explained to the court that the measures should be seen in the context of wider cultural change management in the supervision and leadership being undertaken by Hampshire Constabulary in the operation of the Control Room. **I have taken account of the measures, many of which are of a policy nature, as outlined by Hampshire Constabulary. However, I remain concerned in relation to the matters identified at sub-paragraph b. (above).** **In addition, I am concerned that, although welcoming the local changes implemented by the Grayshott Surgery Practice, The Priory Roehampton**

	and SABP, there is an absence of a wider national structure within the NHS that facilitates the effective passage of patient information between the private and public healthcare sectors. 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. 1. The effectiveness in the supervision of operators handling calls in the Hampshire Police Force Control Room to detect circumstances such as those which involved Mrs. CHRISMAS sooner and to avoid repetition. Evidence of the change required in this respect, was not provided to the court beyond limited training measures; either in the form of a plan to bring such change about, or evidence that such change has otherwise occurred. 2. The passage of information between NHS and private healthcare providers is hindered due to the absence of an adequate structure to share important clinical information about patients in a timely and effective manner.
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 23rd 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: Family of Meghan Irene CHRISMAS Surrey and Borders Partnership NHS Foundation Trust The Priory Hospital, Roehampton [redacted], Consultant Psychiatrist, The Priory Hospital [redacted], Grayshott Surgery, Hindhead, Surrey Hampshire and Isle of Wight Constabulary Surrey Police I may also send a copy of your response to any other person who I believe may find it useful 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	**29th December 2023**	**Darren Stewart OBE**