CORONER'S OFFICE
AREA OF HERTFORDSHIRE

Date: 15 July 2024

Our Ref: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. THE SECRETARY OF STATE FOR HEALTH

2.THE CHIEF EXECUTIVE OFFICER AND CHIEF FINANCE OFFICER OF HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD

1 CORONER

I am Alison McCormick, Assistant Coroner for Hertfordshire

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3 INVESTIGATION and INQUEST

On 7 August 2017 an investigation was commenced by the Senior Coroner for Hertfordshire into the death of Megan Leanne DAVISON. The investigation concluded at the end of an inquest heard on 28th March 2018.

The first inquest conclusion was quashed and a fresh investigation directed by the High Court on 17th May 2022. A second inquest was heard by me from 24th June 2024 to 10th July 2024.

The conclusion of the inquest was:

Ms Davison died by suicide in the context of personality disorder and Type 1 diabetes with disordered eating (also known as T1DE).

The medical cause of death was:

1a Suspension

1b

1c

II Personality Disorder and Type 1 Diabetes with Disordered Eating (also known as T1DE)

4 CIRCUMSTANCES OF THE DEATH

Megan Davison was found deceased at her home address on 4th August 2017, having hanged herself with the intention of ending her life.

The following issues possibly made a more than minimal contribution to Ms Davison's death:

(a) Ms Davison's discharge from the care of the Mental Health Trust on 1st August 2017;

(b) Lack of integration between mental health and physical healthcare systems;

(c) Absence of a recognised diagnosis for Type 1 Diabetes with Disordered Eating (also known as T1DE) and absence of pathways of care for T1DE and Diabetic Ketoacidosis (by way of physical and mental health protocols);

(d) Lack of consolidated records and direct communication systems between different parts of the healthcare system.

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. –

(a) On a national level there is not a system which is capable of being operated in a way which will ensure proper integrated healthcare for patients with T1DE. Specifically, there is no formal diagnosis for T1DE, no treatment pathway for T1DE and no complete treatment pathway for Diabetic Ketoacidosis (DKA), an acute clinical emergency associated with T1DE caused by deliberate omission of insulin, which should be seen as an act of self harm - there being a physical protocol, but no mental health protocol, for DKA. I heard independent evidence from [redacted], Professor of Psychiatry and Medicine at the Institute of Psychiatry, Psychology and Neurosciences at Kings College London that " the lack of a diagnosis for T1DE has an impact because if you don't know what you are looking for and there aren't any criteria that you can screen by then it's very difficult for both patients and clinicians to understand what is wrong with them and this has hampered development of recognition and treatment pathways and building the research evidence". **(Copies of [redacted]s independent expert reports for the Inquest are attached).**

(b) At a local level in East and North Hertfordshire there is no integrated healthcare system for patients with diabetes and eating disorder as there is in the west of the county.

(c) Whilst there have been significant advances in developing shared clinical records systems across primary and secondary care since Ms Davison's death in 2017, none of the shared records systems extends to organisations which are deemed to be private providers, such as The Priory. The perception of healthcare providers such The Priory as "private" providers is a fallacy, because a high percentage of patients looked after by such providers are, like Ms Davison, NHS patients. I heard evidence from the Chief Medical Officer of The Priory that record sharing which includes private providers would help to prevent future deaths.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you, The Secretary of State for Health and the Officers of the Hertfordshire and West Essex Integrated Care Board 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 9th September 2024. 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:

Megan Davison's family

Hertfordshire Partnership University NHS Foundation Trust

The Priory Hayes Grove

Royal Free London NHS Trust

East and North Hertfordshire NHS Trust

North Middlesex University Hospital NHS Trust

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.

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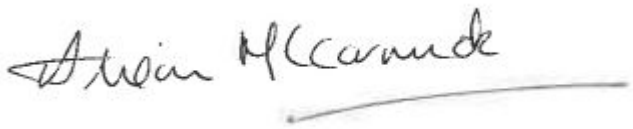
15 July 2024



Signature

Ms. Alison McCormick Assistant Coroner

for Hertfordshire