**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**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1.** The Chief Executive of NHS England<br>**2.** The Chief Executive of NHS Dorset |
| 1 | **CORONER**<br><br>I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 4th April 2023, an investigation was commenced into the death of Emma Victoria Sanders, aged 34 years.<br><br>The investigation concluded at the end of the Inquest on the 18th November 2024.<br><br>The medical cause of death was:<br><br>Ia Hypoxic Brain Encephalopathy<br>Ib Asphyxia<br><br>The conclusion of the Inquest was a narrative conclusion that Emma Victoria Sanders died as a consequence of the self-application of a ligature to her neck, in circumstances where her intention remains unclear. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Emma had a complex mental health history with confirmed diagnoses of Emotionally Unstable Personality Disorder (EUPD) and complex Post Traumatic Stress Disorder (PTSD) and was known to regularly self harm by a variety of means. Emma had a history of opiate dependence and on the 22nd February 2023, she began a period in a detoxification and rehabilitation placement in Cornwall in order to become abstinent from methadone so she could progress to therapy treatment for her mental health diagnoses. Prior to this she had experienced a period of relative stability with her mental health. During this placement the methadone prescription was reduced more quickly than she had experienced before, and she became emotionally dysregulated. Her mental health deteriorated, and her acts of self harm increased as a result of which she |

| | |
|---|---|
| | was taken to the local hospital in Cornwall. The placement was ended on the 7th March as it was felt her risks were too high to be managed in that setting. On the 14th March 2023 Emma was taken to the Emergency Department at the Royal Bournemouth Hospital, Bournemouth after she disclosed that she had taken an overdose of her prescribed medication. At this time the hospital was experiencing extreme capacity pressures and Emma was placed in the cohorting corridor which was being staffed by paramedics due to the capacity pressures. At 18.58 hours, when for a very short period of time there were no staff in the corridor, Emma can be seen on the CCTV of the corridor to secret upon her person a nasal canula with plastic tubing from an equipment trolley. At 19.53 hours Emma went to the toilet in the Emergency Department. At 20.03 hours, Emma was found in a collapsed and unresponsive condition on the floor of the toilet with a ligature fashioned from nasal canula tubing around her neck. Following attempts at cardiopulmonary resuscitation there was a return of spontaneous circulation, and she was admitted to the critical care unit at the hospital where she continued to receive care, however her condition deteriorated, and she died on the 19th March 2023. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br>The **MATTERS OF CONCERN** are as follows:<br><br>1. During the inquest evidence was heard that:<br><br>i. At the time of her death Emma had a Frequent Attender Care plan, or as they are now known a High Intensity Use Care Plan, in place. This plan was agreed by representatives from Dorset Healthcare NHS Foundation Trust (DHUFT) who provide the mental health care across Dorset, a representative from the Royal Bournemouth Hospital, a representative from Poole Hospital and a representative from We Are With You (WAWY) who supported Emma with her substance misuse. The aims of this plan for Emma were:<br><br>• to provide a consistent approach when Emma presented to the emergency department<br>• to streamline her care so that she does not have to wait any longer than necessary in the ED as she has identified this makes her feel worse<br>• to minimise the impact on emergency department resources when Emma attends<br>• to reduce the use of restrictive interventions which may exacerbate Emma's distress<br><br>ii. South West Ambulance Service NHS Foundation Trust (SWAST), who provide the paramedic care in the South West, were not provided with the plan prior to the 14th March 2023, nor were other hospitals Emma may present to, such as the other local hospital in Dorset, Dorset County Hospital, or the hospital in |

Cornwall where Emma was taken to when she self harmed on the 5th March 2023 during her time at the detoxification and rehabilitation placement.

iii. On the 14th March 2023, due to the capacity issues the cohorting area was opened at the Royal Bournemouth Hospital and representatives from SWAST were caring for the patients in the cohorting area. When Emma arrived at the hospital, she was taken to the cohorting area and was booked into the hospital by the triage nurse from the hospital, although was not seen by them and her previous records were not accessed.

iv. There can be a delay in accessing the hospital patient record when a patient arrives at the hospital as following the booking in process, there needs to be a merger of the ambulance paperwork to verify they have the correct person before the hospital patient record can be accessed. The process adopted by different hospitals may cause a delay in access to the hospital patient record and evidence was given that at the Royal Bournemouth Hospital this could be anything up to 10 minutes from experience.

v. When Emma arrived at the hospital she was booked in by the triage nurse between 18.49 and 18.52 hours, however the merger of her records did not happen until 18.59 hours. No representative from the hospital saw Emma prior to her death and she was monitored by the SWAST paramedics in the cohorting area, so there was no access to her patient record which detailed her significant history of self harm and the Frequent Attender Care Plan. The Frequent Attender Care Plan was not followed throughout the 1 hour and 47 minutes Emma was with professionals from when SWAST attended her home address until the time she was last seen prior to her death. Had it been accessed, and followed, there would have been opportunities to discuss with Emma further support for her whilst she was at the hospital and the evidence given by the witnesses who had contact with her that day was that they would have considered managing her care differently.

vi. University Hospitals Dorset NHS Foundation Trust, of which the Royal Bournemouth Hospital forms part, have taken action internally to ensure that a person's records are now available when a person arrives at the hospital and this would include access to Frequent Attender Care Plans, however evidence was given that a similar process around the merger of records is undertaken at other hospitals across the South West, from the experience of SWAST, and this may also be a national issue.

vii. The Summary Care Record (SCR) is accessible to a variety of healthcare professionals and accessible to SWAST.

| | |
|---|---|
| | viii. As per the NHS England website, link found here Summary Care Record - NHS England Digital, "The Summary Care Record (SCR) is a national database that holds electronic records of important patient information such as current medication, allergies and details of any previous bad reactions to medicines, created from GP medical records. It can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care".<br><br>ix. Documents cannot be uploaded to the SCR, however a section can be added to the SCR to detail information such as care plans. Evidence was given that the content of the SCR is controlled by the specific Integrated Care Boards (ICB) covering that area. There are 42 ICBs across England and Wales.<br><br>x. The SCR for Dorset does not include a section to detail the care plans in place for individuals. The Deputy Director for Care for SWAST gave evidence that none of the ICBs in the South West Region has a section in the SCR to detail care plans in place for individuals. IF there were such a section, the GP of the individual would then be responsible for uploading the details to the SCR and then it would be accessible to other health professionals the person comes into contact with nationally.<br><br>2. I have concerns with regard to the following:<br><br>i. There can be a delay in accessing a patient's hospital record and history when they are taken to hospital by a paramedic depending on the method of booking in and triage which could impact on patient care, especially if there are delays in them being assessed such as when they are placed in cohorting areas, and this could lead to a future death.<br><br>ii. The Summary Care Record does not detail care plans in place for individuals in Dorset, the wider South West region and may be nationally. Lack of access to these plans could impact on patient care and lead to a future death. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, 21st January 2025. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>(1) Emma's family<br>(2) Dorset Healthcare University NHS Foundation Trust<br>(3) University Hospitals Dorset NHS Foundation Trust<br>(4) South West Ambulance Service NHS Foundation Trust<br>(5) We Are With You<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>I have also sent a copy of this report to the following persons for their awareness:<br><br>a) BCP Council, as they were involved in the Inquest<br>b) Chief Executive of Dorset County Hospital, Dorset<br>c) [redacted], Service Manager, St Mungo's<br><br>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**<br><br>**26th November 2024** | **Signed**<br><br>  <br><br>**Rachael C Griffin** |