

## **Regulation 28: REPORT TO PREVENT FUTURE DEATHS**

	<p><b>REGULATION 28 REPORT TO PREVENT DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li><b>1 Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust</b></li><li><b>2 Chief Executive, Sherwood Forest Hospitals NHS Foundation Trust</b></li><li><b>3 Secretary of State for Health and Social Care</b></li></ol>
<b>1</b>	<p><b>CORONER</b></p> <p>I am Ms Alexandra Pountney, Assistant Coroner for the coroner's area of Nottingham and Nottinghamshire.</p>
<b>2</b>	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
<b>3</b>	<p><b>INVESTIGATION AND INQUEST</b></p> <p>An investigation into the death of Sophie Louise TOWLE was opened on 28 June 2024, and the final inquest hearing was heard by me, sitting with a jury. The final inquest hearing started on 6 October 2025 and concluded on 24 October 2025.</p>
<b>4</b>	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <ol style="list-style-type: none"><li>Sophie died at Kings Mill Hospital in Mansfield on 27 May 2024 from a pulmonary thromboembolus, referred to variously as a saddle embolus and PE throughout these proceedings. Sophie died whilst she was detained under s.3 of the Mental Health Act 1983.</li></ol>

2. On 27 November 2023, Sophie had been detained under the Mental Health Act 1983 at Derby Royal Infirmary, from where she was transferred into the care of Rotherham, Doncaster and South Humber NHS Foundation Trust (“RDASH”), being admitted to Brodsworth Ward early December 2023. The jury heard evidence that Sophie would regularly self-harm while under the care of RDASH, and that inserting foreign objects into an old self-harm wound on her leg was part of this pattern of self-harm. Towards the end of her admission, Sophie’s observations had been reduced from 1:1 eyesight observations, to having periods when she was not observed. The aim was to reduce observation frequency with a view to transfer to a locked rehabilitation unit.
3. Sophie was from Nottinghamshire, and so Doncaster was not her ‘home Trust’. On 24 April 2024, she was repatriated to Nottinghamshire Healthcare NHS Foundation Trust (“NHCT”) and admitted to Fir Ward at Sherwood Oaks Hospital. The evidence was, and it was accepted by RDASH in the form of a written admission, that the “*communication from RDASH to Sophie, her family and her care co-ordinator from 22-24 April 2024 in relation to the repatriation to Nottinghamshire Health Care NHS FT was poor*”.
4. The jury heard evidence that Sophie did not want to be repatriated to Nottinghamshire and that she held a distrust for the service. The evidence from a variety of witnesses was that the transfer destabilised Sophie. Though whether that was the fact of the transfer, or the way in which the transfer was conducted, is a matter for the jury.
5. During her admission to Fir Ward, the jury heard that Sophie self-harmed on a daily basis. She from the date of her admission until 14 May 2024, Sophie was 1:1 eyesight observations.
6. On 12 May 2024, whilst on 1:1 eyesight observations, Sophie self-harmed [REDACTED] an old self-harm wound on her left leg. She was transferred to Kings Mill Hospital on 13 May 2024, and the decision was made not to remove [REDACTED] from Sophie’s leg. Sophie was discharged back to Fir Ward on 14 May 2024.
7. On 14 May 2024, as she returned from Kings Mill Hospital, Sophie’s observations were reduced on Fir Ward to every 10-minutes. The jury heard evidence that Sophie and her family were unhappy with this decision. The type of self-harm behaviours changed following this decision, and Sophie began headbanging and ligating, which she had not previously done on this admission to Fir Ward.
8. Sophie re-presented at Kings Mill Hospital on 19 May 2024 with an infection in her leg wound. Orthopaedics were consulted by the medical team in ED who were advised that the pen did not require removal. Sophie was discharged with IM antibiotics.
9. On 26 May 2024, Sophie began to complain of chest pain and swelling to her left leg. An ECG was carried out and reviewed by a doctor, though no physical examination was carried out. No abnormality was noted.

10. On 27 May 2024, Sophie complained to a nurse that she felt like she had a chest infection. Sophie was reviewed by the on-call doctor who said no abnormalities were noted on listening to her chest and the observations were in normal range for Sophie, who had a known tachycardia. The jury heard that Sophie was seen by a nurse around 5pm when she did not complain of feeling unwell. At 17:53, the emergency alarm was sounded on the ward following Sophie having a seizure in the communal area. An ambulance was called, and Sophie was transferred to Kings Mill Hospital where she sadly died following a cardiac arrest.

11. Post-mortem findings confirmed that Sophie had suffered a large pulmonary embolus that occluded blood flow to both lungs, originating from a deep vein thrombosis in her left leg. The expert evidence together with the pathological evidence concluded that ██████ caused immobility, which contributed to the formation of the blood clot which ultimately killed Sophie. The failure to consider VTE prophylaxis was also causative, and had Sophie been prescribed enoxaparin or similar on or around 14 May 2025, she probably would have survived. This was admitted by NHCT.

**5 CORONER'S CONCERNS**

During the course of the inquest I heard evidence giving rise to concern. 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. Lack of joint agency policy/cross-sector working between physical and mental health trusts in relation to the insertion of foreign bodies**

I heard evidence that it would have been beneficial in Sophie's case for there to have been an MDT between Sophie's psychiatric team (NHCT) and her physical health team (Orthopaedics and Anaesthesia at SFH). The reason that this would have been of assistance is due to the complexity of cases where there are physical and mental health considerations in play for decisions around the management of a foreign body.

There is no embedded mechanism for arranging MDT meetings, or indeed for any liaison or contact between these teams, in such cases. Similarly, there is no policy or procedure which prompts clinicians from either team to consider an MDT in these cases or, at the very least, picking up the phone for a consult.

If this had happened in Sophie's case, it seems likely that the outcome in relation to the management of the foreign body would have been different. Sophie's psychiatric team

were keen for removal and were satisfied that they could implement a robust policy to avoid re-insertion, which was one of the main concerns of the Orthopaedic team.

In my opinion there is a risk that future deaths could occur unless action is taken in relation to this issue.

## **2. VTE risk assessment and associated policy and training at NHCT**

During the course of Sophie's inquest, I heard evidence which concerns me that there is a lack of clarity in relation to the current local VTE policy. I was provided with version of the policy that I have assured was current at the outset of the inquest. All witnesses who were directly asked about this policy recognised it as the current policy in its terms. On 22 October 2025, I was sent late disclosure of the correct updated policy which was ratified in April 2025 (available to view from May 2025), some 6 months before the inquest hearing began. The updated policy was materially different in its terms on the frequency and circumstances in which VTE risk assessments should be undertaken. This gives rise to a number of specific concerns:

- A) The staff do not have a proper working knowledge of the current local VTE policy.
- B) The knock-on concern from this is that the training around the VTE policy is not robust in its content or is otherwise not being properly engaged with by staff.
- C) The current policy has been weakened in its terms, in particular at paragraph 1.6 where the requirement for an updated assessment of risk on at least a weekly basis has been removed. I understand from the evidence that, notwithstanding the wording changes to the policy, prompts are given on VTE risk assessment at the weekly MDTs. I am concerned that the policy is not reflective of the encouraged practice on the Wards. I am also concerned that, whilst this happens on Fir Ward, it is important that guidance is consistent across all wards within the Trust. The common document across the wards is the local policy and therefore I am concerned about the clarity and robustness of its terms.

In my opinion there is a risk that future deaths could occur unless action is taken in relation to this issue.

## **3. The disbanding of the Personality Disorder Hub at NHCT**

I am told that as of mid-October 2025, the Personality Disorder Hub at NHCT has been disbanded. Neither the witness who worked within the disbanded service, nor the policy witness for NHCT was able to give me any particulars as to the arrangement of the new service, beyond a general statement that it was being absorbed into the LMHTs. I was told by the witness who had worked within the PDH that his understanding for his LMHT was that there would be a personality disorder service which would consist of him, as that was his specialist interest.

Given the current inquiry into Mental Health Services in Nottinghamshire, and particularly the care of those patients with personality disorders within the service, I am concerned about the lack of clarity within the Trust as to the current position and level of service available to patients with personality disorders.

I am concerned that an absence of a specialised and central service dealing with personality disorder patients, with care provided by specialists in personality disorder, causes a risk of future death.

**4. The policy and procedures around the management of insertion of foreign objects for SFH**

I have had sight of the newly ratified local policy for management of insertion of foreign objects at SFH. I am concerned that its content is lacking in specificity, the language used is vague and open to interpretation, and it does not provide clear advice for medical professionals accessing it for guidance. It is not a robust policy in its terms.

Further, I am concerned that it does not make any reference to consultation of mental health services, whether local or acute, at all. Given that the policy recognises that in the majority of cases where management of insertion of foreign objects the patient has a mental health condition, I find this particularly concerning.

Based on the evidence that I have heard, I am also concerned that there is no effective communication of the policy and guidance to Trust staff on this issue.

**5. Staffing on mental health wards**

I have been told by numerous witnesses to this inquest that the staffing levels on Fir Ward both at the time of Sophie's admission, and now, are insufficient. The result of that, I am told, is that the wards cannot run safely and patient care and safety negatively impacted. Staff simply do not have time to complete essential tasks on the ward (like physical observations, completing care plans and risk assessments etc.) or give the patients the 1:1 time they require. I saw a genuine concern and regret on the faces of the hardworking healthcare professionals who gave evidence in my court of the course of this inquest, some were brought to tears. The job is relentless, and they do not feel supported by virtue of a lack of staff numbers and experience. I am told that this remains the case notwithstanding that the minimum staffing levels as governed by the Department of Health and Social Care are being met. This is an issue of grave concern. It suggests that the minimum levels of staff are too low, the staff pool is not sufficiently experienced across the board, that the wards are not functioning safely and that patients are at risk of death as a result.

<b>6</b>	<b>ACTION SHOULD BE TAKEN</b>  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.
<b>7</b>	<b>YOUR RESPONSE</b>  You are under a duty to respond to this report within 56 days of the date of this report, namely by 19 December 2025. 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.
<b>8</b>	<b>COPIES and PUBLICATION</b>  I have sent a copy of my report to:  <b>All IPs</b>  <b>Chief Coroner</b>  who may find it useful or of interest.  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. She may send a copy of this report to any person who she 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: 24 October 2025**

**Ms Alexandra Pountney**

**Assistant Coroner**

**Nottingham and Nottinghamshire**