

Corporate Services  
Ashbourne Centre  
Kingsway Site  
Kingsway  
DERBY  
DE22 3LZ

[REDACTED]  
[REDACTED]  
20 January 2026

Susan Evans  
HM Area Coroner for Derby and Derbyshire  
Town Hall  
Rose Hill  
Chesterfield  
Derbyshire  
S40 1LP

Dear Ma'am

**Re: Regulation 28 response: an inquest touching the death of Hannah Booth**

May I first begin on behalf of the Trust by conveying my condolences to the family of Hannah for their loss.

Below the Trust has responded to matters that are within its control and relate to the Trust as set out in your Regulation 28 report dated 9 December 2025:

SystemOne 'alert'

Following the conclusion of the Inquest, the Perinatal CMHT has undertaken an audit of GP's within its catchment area who do not use the same electronic patient record, SystemOne and have shared this information with all clinicians and administrators internally for awareness. To ensure continuing knowledge internally of GP's who do not use SystemOne, the Trust is in the process of adding an 'alert' onto patients' medical records as a reminder / notification. The Trust has taken this specific action wider than the Perinatal CMHT to include the High Peak CMHT / CRHT as that is the geographical area that the Trust covers where GP's do not have SystemOne; in other areas GP's do have SystemOne.

Information leaflet to GP's on referral

The Perinatal CMHT has drafted an information leaflet for GPs setting out that this Trust and the GP practice use different electronic patient record systems, highlighting the impact of this and detailing risk mitigation. This leaflet will be sent to GPs on receipt of a referral from them if they do not have the same electronic patient record. An additional page has been added to the e-referral document for professionals regarding the sharing of contextual information around the patient. A patient will also be informed that their GP is not on the same electronic patient record so that they too are aware that information sharing is not automatic at the time of their appointment.

Dissemination of learning

The learning identified as part of the Trust's Patient Safety Incident investigation and the inquest has been added to the agenda for the next stakeholder event.

Working alongside DCHS

Further, and in addition, the Trust is currently discussing with Derbyshire Community Health Services NHS FT ('DCHS') the development of Guidance regarding when DCHS' health visitors will cross reference the medical notes for baby and mum.

Action plan oversight

The actions are detailed within an action plan which I append to this letter for ease and assistance and are being overseen through the Trust's established clinical governance and patient safety arrangements, with progress monitored and assurance provided through those governance forums.

I hope that the above information provides you and the family of Hannah the reassurance that the Trust takes learning very seriously and continually seeks to improve. I am mindful that some of the actions detailed in this letter have not yet been completed and with that, I have requested that an update be sent to you, and the family of Hannah, if they would like continued communications from the Trust, in August 2026.

Yours sincerely



**CHIEF EXECUTIVE**

Enc. Action Plan