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23rd January 2026

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Hannah Louise Booth who died on 6 January 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 9 December 2025 concerning the death of Hannah Louise Booth on 6 January 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Hannah's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Hannah's care have been listened to and reflected upon.

Your Report raises the following concerns:

1. If perinatal mental health services had known about Hannah's increasing frequency of contact with services about her baby's development, it would have prompted further contact by them with Hannah and prompted a review of risk and support offered.
2. There was no single electronic patient record accessible to all services as the perinatal mental health and the health visitors did not use the same electronic patient record.
3. There are no policies, guidance or any shared understanding between services of what might be relevant information to be shared and when.
4. There are no policies or guidance regarding when information potentially relevant to both mother and baby should be placed in both records and cross referenced.

Single Electronic Patient Record

NHS England recognises the challenge of separate systems being used by different health and social care organisations. New initiatives and systems are being designed to integrate records. NHS England has invested £20 million to connect care records across England by March 2026. This will facilitate the safe and secure exchange of electronic health data across different systems, devices and applications. It is also expected that this will improve the information available to health and social care staff.

Work is also progressing to develop a [Single Patient Record](#) (SPR). The SPR aims to provide a clear, unified view of a patient's health and care history, regardless of where

care has been delivered, and will enable seamless access to information across all care settings, including primary, acute and community services.

Perinatal Mental Health Support and Guidance

The NHS has expanded specialist perinatal mental health support and access has more than doubled (113%) from 31,163 patients in March 2020 to 66,468 in October 2025. NHS England previously published guidance on [perinatal mental health care pathways](#) in May 2018, to support all healthcare professionals working across the wider perinatal mental health pathway in identifying cases requiring specialist input. This is supported by e-learning resources for all staff, including modules for health visitors and a broader perinatal mental health resource covering risks to parents.

Healthcare professionals are encouraged to seek advice from their local specialist perinatal mental health team as required to support assessment, risk management, and care planning. All healthcare [systems](#) are expected to have clear and documented local perinatal mental health pathways in place.

The National Institute of Health and Care Excellence (NICE) has published guidance on antenatal and postnatal mental health ([NICE QS115](#)), which recommends routine enquiry about emotional wellbeing at every antenatal and postnatal contact, recognising that risk can change over time. Where a red flag is identified, urgent discussion with the Specialist Perinatal Community Mental Health Team is required, with crisis services accessible outside of normal working hours where necessary. All assessments, identified risks and actions taken are to be documented.

Sharing of information between services

Historically, different care settings have adopted different clinical systems to maintain a clinical record; some areas have adopted the same electronic patient record (such as SystemOne), whereas other areas have adopted shared care records which can provide access to records from different care settings. The GP record is available via [GP Connect](#), the [Summary Care Record](#) and the [Medical Interoperability Gateway \(MIG\)](#), but the availability and content does vary across England. NHS England does not mandate IT infrastructure.

NHS England is aware of the challenges in sharing medical records between providers and the variability between areas using different technologies. We are also aware that use of the SCR is variable across different care settings.

We are therefore working across the health system to support greater integration and awareness of record sharing between providers. We are also working with the SCR Programme to support wider access to relevant patient information.

At present, [Integrated Care Boards \(ICBs\)](#) are responsible for the commissioning, implementation and integration of primary care solutions.

The newly published [Fit for the future: 10 year Health Plan for England](#), which sets out the government's plan for healthcare in England over the next 10 years, also includes a commitment to give patients a 'single, secure and authoritative account of their data

– a single patient record – to enable more coordinated, personalised and predictive care’. Alongside this, the 10 year Health Plan emphasises working towards the Single Patient Record (SPR) with the Maternity First approach, which prioritises the perinatal period. The SPR introduces new concepts such as being able to ‘red flag’ a contact with a health visitor, which then becomes part of the same medical record seen by the GP.

Placing relevant information in both mother and baby records

In regard to your concern that there are no policies or guidance that advise when information potentially relevant to both mother and baby should be placed in both records or cross referenced, the current position is that parents and children must have their own separate records which should not be merged ([NHS Records Management Code of Practice](#)).

Clinical information that impacts care should be documented in the record where it supports ongoing care and decision making. If information in one record (e.g. the mother’s mental health) is relevant to another record (e.g. safeguarding a baby’s welfare), clinicians should either document that it has been shared (and with whom and why) in both records, or provide a summary/cross reference in the other record based on clinical need and consent. Discussions regarding consent and confidentiality and decisions about information sharing should also be clearly documented.

Following this case, NHS England via the regional Perinatal Mental Health networks will encourage specialist perinatal mental health teams to include record keeping as a component of their training to the wider pathway, to help support staff to understand their experiences for documenting assessments, risks, red flags, information sharing and consent.

Maternal health information being hidden in the baby’s records is a known risk that the ‘Born Digital’ ambitions for the 10 year Health Plan aims to address. This includes the introduction of a link between mother and baby from the first maternity booking. By forming this link at the start of the SPR, this should ensure that the mother-baby relationship is treated as a single clinical entity, allowing a clinician viewing either record to make alterations or updates for relevant health markers.

Another new development is to include The Personal Child Health Record (The Red Book) in the [NHS App](#) as part of the SPR, thus allowing any flags entered into the Red Book to flag into the mother’s record as well, subject to the usual governance and safeguarding requirements.

Sharing of information by Health Visitors

The Department of Health and Social Care (DHSC) is due to publish refreshed Healthy Child Programme guidance in early February 2026. Their [current guidance](#) highlights the importance of continuity of care by a named health visitor, particularly during the antenatal and immediate postnatal period. This can help to mitigate against contact being seen in isolation, as the health visitor develops a relationship with and an understanding of the individual family’s needs, building a holistic picture. This

continuity of care also supports earlier identification, combining the assessment skills of the health visitor and the confidence of the parent(s) to share concerns.

Health professionals have a legal duty to share patient information where they consider it to be in the patient's best interests. This is essential for safe coordinated clinical care. The Healthy Child Programme guidance reflects these requirements to share information as well as those related to record keeping.

The guidance also includes a High Impact Area on Supporting Maternal and Family Health, which sets out the heightened risks during the antenatal and postnatal period, expectations around working in partnership with other services, continuity of care with midwifery services and the importance of assessing maternal (and paternal) mental health at every contact.

The updated guidance will be published on the gov.uk website and will be available to all 0-19 health commissioners, providers and practitioners, educators, and regulators. NHS England will ensure this guidance is cascaded via our Regional Chief Nurses to ensure Trusts are highlighted to the updated guidance.

Regional Oversight

NHS England's Midlands Region have been informed by Derby and Derbyshire ICB that they are committed to working with NHS England on the areas that extend beyond their organisational influence. In particular, the matter of concern related to the cross-referencing of information in the records of mother and baby, which will have a national impact.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Hannah, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



National Medical Director
NHS England