

IN THE CHESTERFIELD CORONER'S COURT

BEFORE HIS MAJESTY'S CORONER FOR DERBY & DERBYSHIRE

THE INQUEST TOUCHING THE DEATH OF HANNAH LOUISE BOOTH

RESPONSE TO REGULATION 28 – SETT VALLEY MEDICAL CENTRE

1. H.M. Coroner Evans for the Coroner Area of Derby & Derbyshire has made a Regulation 28 Report – Action to prevent deaths dated 9 December 2025 (“**the Regulation 28 Report**”) concerning the death of Hannah Louise Booth (“**the Deceased**”). This arises from the Inquest of 2 December 2025 which concluded on 8 December 2025 (“**the Inquest**”).
2. Sett Valley Medical Centre (“**the Practice**”) respond in accordance with Regulation 29 of the Coroners (Investigations) Regulations 2013 (“**the Response**”).
3. H.M. Coroner Evans’ concerns are set out in bold italics, with the Practice’s Response below:

The MATTERS OF CONCERN are as follows:

(brief summary of matters of concern)

This inquest has exposed important issues with information sharing between services and also within services. Those issues are:

- ***Difficulties encountered because different IT systems were being used for record keeping in different services. Essentially a lack of a single patient record.***
- ***A lack of a shared understanding of what is relevant information and needs to be made available to other services.***
- ***Relevant notes being made in records of baby and not repeated in notes of the mum.***

The Practice held a Significant Event Meeting on 12 January 2026 to discuss the Regulation 28 Report.

1 Sett Valley, the health visitors and perinatal mental health services all had information about Hannah that was potentially relevant to her mental health, but none had the whole picture. It was evident that had those within the perinatal mental health services 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. They did not know and there was no further contact.

At the Significant Event Meeting the Practice discussed the fact that we have the ability to view SystemOne but this ability is quite limited as only the patient's most recent entries can be viewed. Staff would need to have a reason to access this information as it is not feasible to check this for every patient. We as a practice refer patients to a number of other services which use different IT systems such as Mental Health Services, Hospitals and Community services. It was agreed that we will provide training for the team on using the interoperability function in Emis to view SystemOne and this training will be given within 2 months of this Response.

As a Practice we are constantly assessing risk on an individual patient basis and we share relevant information with those services if and when deemed necessary. We discussed how perinatal mental health is a specific, small, cohort of patients who are known to be at increased risk of mental health problems who can deteriorate rapidly, and it was agreed that it would be useful to know which patients are under the specialist team. We considered how to make all staff aware that a patient is under the care of the perinatal mental health team and a decision was made to add an alert to a patient's records when they are referred to the perinatal mental health team. A screen alert is now put on the notes of both the mother and their children under 2yrs. Going forwards all patients referred to the perinatal mental health team will be discussed at our MDT meetings, so all members of the team are aware and at the monthly child safeguarding meeting with the health visitors.

We will also write to the perinatal mental health team asking them to inform us of the outcome of referrals and whether a patient has been accepted. Similarly we will write to the health visitor team asking them to inform us when they refer a patient to the perinatal mental health team as we currently are not aware unless the patient informs us.

With regards to sharing ongoing information with the perinatal mental health team it was discussed whether clinicians should request for the secretarial team to email any consultations relating to mental health (not just a deteriorating condition) and the perinatal mental health team can decide whether this is relevant to the care they are providing to the patient. However, it was felt that emailing every consultation to the perinatal team would put an unsafe burden on the perinatal team and we as a Practice consider that it is better and safer for us to continue with our normal practice of sharing only relevant contacts if we feel it is clinically indicated. This is consistent with the hundreds of other specialities/patient groups that we consult with.

2 There was no single electronic patient record accessible to all services. Whilst the perinatal mental health and health visitors used SystemOne, Set Valley did not. The

health visitor had not informed Sett Valley about the contact Hannah had had with them on 27th December so that the GP seeing Hannah on 31st did not know that Hannah was beginning to make increased contact with services about her concerns and did not share any information about that consultation with other services.

The Practice provides primary care medical services via a Personal Medical Services (PMS) contract commissioned by NHSE England (“NHSE”) and the Derby and Derbyshire Integrated Care Board (ICB). It is part of a Primary Care Network (“PCN”) comprising 8 practices serving approximately 60,000 patients across North Derbyshire, all of which use the EMIS software system. EMIS and SystemOne are the most commonly used electronic GP medical record software systems in the UK. EMIS is used by over 50% of GP practices in the UK and by all 8 practices in our PCN. Whilst most practices in Derbyshire use SystemOne, all Practices in the High Peak area use EMIS. It is vital for effective and safe working across the Practices and for our patients to have access to the shared PCN services including the home visiting service, pharmacy team, social prescribers and others. EMIS is also used by the local provider of outpatient services 3V Healthcare Limited, so in the community clinicians at outpatient appointments have access to the patients’ EMIS notes, which improves safety for patients accessing those services. The Practice is integrated into all the PCN services. Changing over to SystemOne would significantly increase risk in many of these areas.

The development of the ability for electronic GP medical record systems such as SystemOne and EMIS to communicate with each other and allow sharing of clinical information, is not within the control of any individual GP practice, including ours. This is a matter that falls under the responsibility of the service commissioners at Derbyshire-wide level, specifically the NHS Derby & Derbyshire Integrated Care Board (ICB), which is responsible for commissioning services, including general practice, in the area. Individual practices, including ours, have no authority to determine the specifications of such services, nor are they involved in the due diligence processes related to the Information Management and Technology (IM&T) aspects of these systems.

As such in respect of this Concern we consider we cannot proactively do anything as it is a commissioning issue.

3 There was increasing contact with health visitors that was not escalated to or shared with perinatal mental health. The significance of the increased contact, to Hannah’s mental health, did not appear to have been understood. The concerns raised at each contact around her baby’s development were dealt with at face value with exploration and examination of

her baby's development and reassurances given to Hannah regarding the particular concerns raised. The evidence revealed that it was not the individual concerns raised that were relevant to Hannah's mental health but the fact that she was making more frequent contact which suggested she was struggling. There are no policies, guidance or any shared understanding between services of what might be relevant information to be shared and when.

We do not consider that a policy or guidance can be of assistance here. As stated above, the Practice's ability to view SystemOne is limited but we will provide training for the team on using the interoperability function in EMIS to view SystemOne within 2 months of this Response.

A screen alert is now added to a patient's records when they are referred to the perinatal mental health team. The alert is put on the notes of both the mother and their children under 2yrs. In addition, all patients referred to the perinatal mental health team will be discussed at our MDT meetings and at the monthly child safeguarding meeting with the health visitors. As above, we are also writing to the perinatal and health visitor teams to ask them to inform us about referrals but cannot say when/if this will occur or whether it will be possible.

We have discussed the issue of sharing ongoing information with the perinatal mental health team but we consider that emailing every consultation to the perinatal team would put an unsafe burden on the perinatal team and it is better and safer for us to continue with our normal practice of sharing only relevant contacts if we feel it is clinically indicated. This is consistent with the hundreds of other specialities/patient groups that we consult with.

4 Within both Sett Valley and health visitor records there was potentially important information relevant to Hannah's mental health recorded only within her baby's records. At any future appointments concerning Hannah the relevant medical history available on her record would have been incomplete. It also meant that whilst the perinatal mental health services had access to the health visitor notes in relation to Hannah (because they both used SystemOne), even had they had cause to look at Hannah's notes they would still not have had all relevant information. There are no policies or guidance regarding when information potentially relevant to both mother and baby should be placed in both records or cross referenced. This appears to be particularly important in the perinatal period.

At the Significant Event Meeting it was agreed that in circumstances where a child whose mother is under the perinatal mental health team is seen and there are significant concerns about the mother's mental health, the clinician should document this in the mother's notes and ask

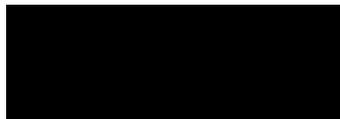
the secretary team to send consultation notes to the perinatal mental health team. This has already been implemented. The clinician will also arrange appropriate follow up for the mother, considering continuity of care and communicate with relevant clinicians within the team if appropriate. It was also agreed that a note should be added to the child's record to please see the mother's notes as we are not able to document in the child's record about the mother's health due to patient confidentiality.

4. The main measures to be implemented as a result of the Significant Event Meeting are:
 - Screen alerts on notes of mother/children under 2 where mother is under the care of the perinatal team (this has already been implemented);
 - Patients under the care of the perinatal team to be discussed at practice monthly MDT meetings and child safeguarding meetings with the health visitors (this has already been implemented);
 - Asking the perinatal team to send acknowledgement of receipt of our referral including whether it has been accepted as urgent or routine. We will write to them within 2 weeks of this Response
 - Asking the Health Visitor team to inform the practice if they have referred a mother to the Perinatal Team. We will write to them within 2 weeks of this Response.

5. We hope the above proposed measures are constructive and useful. The whole practice team also completed suicide prevention training on 7 January 2026. This has refreshed everyone's awareness of how to support patients, and we discussed increasing the use of safety plans and resources available to patients.

Dated this 29th day of January 2026

Signed:

A solid black rectangular box used to redact the signature of the person on behalf of the medical centre.

Dr Blackburn, on behalf of Sett Valley Medical Centre, Hyde Bank Road, New Mills SK22 4BP