Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** 1 Sett Valley Medical Centre 2 Derbyshire Community Health Services NHS Foundation Trust 3 Derbyshire Healthcare NHS Foundation Trust 4 NHS Derby & Derbyshire Integrated Care Board 5 NHS England
1	**CORONER** I am Susan EVANS, Area Coroner for the coroner area of Derby and Derbyshire
2	**CORONER'S LEGAL POWERS** 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** On 10 January 2025 I commenced an investigation into the death of Hannah Louise BOOTH aged 42. The investigation concluded at the end of the inquest on 08 December 2025. The conclusion of the inquest was that: On the 6th of January 2025 Hannah Booth was found to have drowned in the Goyt River. She had sent a message earlier that morning evidencing her intention to take her own life. She had given birth to her daughter on 15th of July 2024 and had subsequently been diagnosed with post-natal depression. She had expressed unfounded concerns regarding maternal bonding, the health and development of her baby and that she herself might be detrimentally affecting that development. Her concerns remained, and were echoed in her final message, despite reassurance from healthcare professionals that there was no evidential basis for any of them.
4	**CIRCUMSTANCES OF THE DEATH** 1. Hannah Booth became pregnant after having IVF and gave birth to her daughter on the 15th of July 2024. She described the birth as traumatic. She was diagnosed with post-natal depression. She had a previous history of an eating disorder, and her mother had died after taking her own life. 2. On the 25th of November Hannah had a consultation with a GP at Sett Valley Medical centre due to her concerns regarding lack of sleep, bonding with her daughter and her isolation from other new mums. Hannah spoke of thoughts of self-harm however had no specific intentions or suggestions of self-harm and said she would not leave her daughter who relied on her for feeding. An urgent referral was made to the perinatal mental health

services because of Hannah's low mood, her persistent inability to sleep, alongside her intrusive thoughts about death as well as her family and eating disorder history.

3. The referral was triaged by the perinatal mental health services, and it was treated as routine. There had been no further liaison with the GP regarding her reasons to have considered the referral urgent. Hannah was given an appointment for an initial focused assessment on 16th December, the result of which was to place her on a waiting list for a full 'core' assessment. She was offered nursery nurse support and the opportunity to attend a reflective programme looking at bonding and attachment. Hannah did not appear to want to engage with the reflective programme although she did contact the perinatal mental health services to speak to a nursery nurse due to her concerns around bonding. Her last contact with anyone from perinatal mental health services was on 24th December.

4. However, Hannah did contact the single point of contact for her health visitor on 27th December expressing concerns about her daughter's development. She was offered a face-to-face appointment with them on 6th January 2025. Later the same day she sent a detailed text message to her health visitor expressing her anxieties about her daughter's development and concerns that she might have had a negative impact on that development. Hannah's appointment for 6th January was brought forward to the 2nd. The record of that text message was placed in her baby's electronic patient records on SytmOne rather than on Hannah's.

5. Hannah placed a further call to the single point of access for the health visitors on 30th January and spoke to a health visitor the following day, 31st December. The appointment for 2nd January remained.

6. The same day, 31st December, Hannah, her partner and her daughter saw a different GP (from the one that made the referral to perinatal mental health) within Sett Valley. Hannah raised concerns about the health and development of her daughter. The GP examined and observed the baby, discussed Hannah's concerns and sought to reassure Hannah. It is evident that Hannah needed to be reassured more than once and appeared anxious. Up until this point in the consultation the GP had been documenting and considering only baby's notes, however, the consultation shifted in focus to Hannah, due to her anxiety, and so her notes were then consulted. It was then evident that there had been a previous referral to the perinatal mental health services. The GP was unaware of any previous contact with the health visitor service about the same concerns. The contact had not been shared with Sett valley and Sett Valley did not use the same note recording system as the health visitors, SystmOne, and so did not have access to that information within the notes. The notes relating to the consultation on 31st were made by the GP on the baby's patient records rather than Hannah's. The perinatal mental health services were not informed of this consultation and as users of SystmOne, they did not

	have access to this information from the notes. 7. During the planned home visit by a health visitor on the 2nd of January 2025 and during a telephone call ahead of that visit, Hannah raised essentially the same developmental concerns regarding her baby. These concerns were noted in baby's patient records and not Hannah's. Hannah's contact with the health visitors was not raised or shared with any other service. 8. On the 6th of January 2025 Hannah sent a text message to her partner evidencing her intention to take her own life and echoing her previously raised concerns that she had detrimentally affected her daughter's development. She was later found to have drowned in the river.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters 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: (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. Further detail: 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. 2. There was no single electronic patient record accessible to all services. Whilst the perinatal mental health and health visitors used SystmOne, Sett 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. 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. 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 SystmOne), 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.
6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by February 03, 2026. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or

	of interest. 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: 09/12/2025** [redacted] **Susan EVANS** **Area Coroner for** **Derby and Derbyshire**