COUNTY OF DEVON, PLYMOUTH AND TORBAY CORONER AREA

REPORT TO PREVENT FUTURE DEATHS

REGULATION 28
CORONERS (INVESTIGATION) REGULATIONS 2013

JOHN EDWARD BRYNMOR PHILLIPS

HM AREA CORONER
NICHOLAS LANE

1.	CORONER I am Nicholas Lane – HM Area Coroner for County of Devon, Plymouth and Torbay.
2.	DATE OF REPORT 22 June 2026.
3.	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.
4.	THIS REPORT IS BEING SENT TO: 1) Chief Executive Officer **- NHS England** [redacted] You are under a duty to respond to this report within 56 days of the date of this report – **17 August 2026.** I may extend the required date for response, if an application (with reasons) is made by you.
5.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's PFD Publication Policy (2026), you should send any representations that you wish to make regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for their determination. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

	The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpage – Non-responses to Prevention of Future Deaths (PFD) reports – Courts and Tribunals Judiciary.
6.	OVERVIEW I am concerned that the national SystmOne electronic patient record operates in an unsafe way, owing to the ability for records to be activated/deactivated at different organisations at any time, with little or no safeguards, which is likely leading to unsafe clinical practice.
7.	ACTION SHOULD BE TAKEN In my opinion, unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe that your organisation has the power to take such action.
8.	INVESTIGATION and INQUEST On 7 November 2022 an investigation was commenced into the death of John Edward Brynmor Phillips. The investigation concluded at the end of the inquest hearing on 18 June 2026 at Exeter Coroner's Court, heard by HM Area Coroner Nicholas Lane together with a jury. Section 2 of the Record of Inquest (which recorded the medical cause of Mr Phillips's death) was determined by the jury as: *1a) ligature suspension* Section 3 of the Record of Inquest (which set out how, when and where Mr Phillips came by his death) was determined by the jury as: *'Mr Phillips was found unconscious in his cell (B3-12 at HMP Dartmoor) on the morning of 29th October 2022. Mr Phillips had deliberately used a ligature to end his own life as evidence by the suicide note that he had left. Resuscitation was attempted by prison officers and medical staff, and was continued by the ambulance service until he was pronounced deceased at 9.39am in his cell.* *There was a delay of approximately 2.5 months in John Phillips undergoing a mental health assessment at HMP Dartmoor - this delay came about because once John Phillips had been transferred to HMP Dartmoor from a different prison his prison medical records were activated by the healthcare team at this other prison - with the unintended consequence of deactivating the medical records at HMP Dartmoor, leading to the cancellation of a referral that had been tasked to the mental health team at HMP Dartmoor - however, this delay did not materially contribute to John Phillips' death.'* Section 4 of the Record of Inquest (which set out conclusions in respect of Mr Phillips' death) was determined by the jury, in narrative form, as: *'Over the course of his time at HMP Dartmoor Mr Phillips intermittently but frequently suffered repeated low moods, paranoia and anxiety, particularly relating to his long term status as an IPP and EPP prisoner. This led to his intentional use of a ligature to end his life by suicide.'*
9.	CIRCUMSTANCES OF DEATH Mr Phillips was 37 years old at the time of his death. He had spent a significant amount of his adult life as a serving prisoner, including receiving an IPP sentence. Having been recalled to prison in 2020 (and then sentenced to an additional term of imprisonment in November 2021 for further offending) he was transferred (at his request) to HMP Dartmoor in July 2022.

	Mr Phillips had a history of low mood, anxiety and paranoia – he reported that he had considered taking his own life on a number of occasions and had made one significant attempt. Although Mr Phillips did not obviously suffer from overt poor mental health to those who were involved in his care and management at HMP Dartmoor, he had requested, at his reception health assessment in July 2022, to be referred to the prison mental health team for assistance. This referral was made immediately. The inquest heard evidence that the referral to the mental health team was cancelled, or 'deactivated', on Mr Phillips' SystmOne records, and that this likely came about owing to a member of staff at HMP Parc, the establishment from where Mr Phillips had been transferred, carrying out an 'uploading' exercise relating to Mr Phillips' SystmOne records – this uploading exercise was apparently a well-known feature of how SystemOne needed to be operated (in the prison setting at least). The inquest heard evidence that in consequence of the uploading of Mr Phillips' SystmOne records at HMP Parc, his current SystmOne records at HMP Dartmoor became deactivated, with associated current tasks (including the referral to the mental health team) being cancelled. It appears that no member of the healthcare staff at HMP Dartmoor realised that this deactivation of the records had taken place – they were swiftly reactivated (by a similar uploading process taking place at HMP Dartmoor) but the previous tasks remained cancelled. Over two months later, Mr Phillips enquired about why he had not yet been seen by the mental health team, as he had initially been referred. This led to a swift triage and an assessment of Mr Phillips by a mental health nurse. Mr Phillips was commenced on anti-depressant medication and placed on a waiting list for psychological therapy, to try and address his symptoms of low mood and anxiety. This 2.5 month delay in Mr Phillips undergoing a mental health assessment and treatment commencing were directly owing to the SystmOne records deactivation incident. On 29 October 2022 Mr Phillips was found to be unconscious in his cell, having used a ligature to take his own life. The jury determined that Mr Phillips died by suicide – the delay in Mr Phillips being assessed by the mental health team was recorded by the jury in their determinations, although it was noted that this did not materially contribute to his death.
10.	<u>DETAIL OF CONCERNS</u> During the course of the investigation and inquest I obtained and heard evidence giving rise to a 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 **MATTER OF CONCERN** is as follows: The national SystmOne electronic patient record operates in an unsafe way because it appears to allow a patient's record to be accessed (which might be for a necessary administrative reason) by a member of staff in an organisation previously involved in the patient's care, which seems to have the automatic effect of deactivating the patient's active record in an organisation currently involved in the patient's care (and associated appointments, tasks, treatment plans etc), without this being obvious to anyone – this leads to the removal of important and current tasks, referrals and appointments for the patient whilst they are being cared for by the current organisation and will likely result in unsafe clinical care being provided by NHS Trusts. The inquest heard evidence (from clinicians involved in providing healthcare within prisons) that this functionality of SystmOne is acknowledged and that, accordingly, steps are being taken by the healthcare provider (Oxleas NHS Foundation Trust) to mitigate against the risks of this happening and to try and ensure that when the problem arises, it is identified and that there is consideration of whether clinical care and treatment plans have been affected. However, it appears that, given SystmOne is used nationally by numerous healthcare providers, a technological solution to prevent this issue from occurring (or identifying clearly that it has occurred for those using the system) would be preferable and improve patient safety.

	This issue was identified by the clinical review that formed part of the PPO investigation into Mr Phillips' death. The clinical review made the following recommendation to NHS England: **- NHS England to consider the system wide SystmOne administrative risk highlighted in this case and to take any action deemed appropriate to safeguard and mitigate the future risk of reoccurrence.** It is not clear whether any action has been taken following this recommendation – those giving evidence at the inquest who were familiar with using SystmOne were not aware that any changes had been made to its functionality in respect of this issue.
11.	<u>COPIES AND PUBLICATION OF THIS REPORT</u> I have a duty to send a copy of my report to every Interested Person (IP) who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I confirm I have sent the report to: 1) Mr Phillips' family (IP). 2) Oxleas NHS Foundation Trust (IP). 3) Devon Partnership NHS Trust (IP). 4) Practice Plus Group (IP). 5) HMPPS / GLD (IP). 6) PPO – for the attention of the PPO Ombudsman who is the author of the PPO report and to the author of the PPO clinical review (IP). I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with the Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to Section 5 above for additional information relating to the publication of reports and responses.

12.	Date: 22 June 2026 Signature: [redacted] **Nicholas Lane** **HM Area Coroner** *County of Devon, Plymouth and Torbay* Courts and Tribunals Judiciary