LIST OF CORONERS' PREVENTION OF FUTURE DEATHS REPORTS RELATING TO CARE PROVIDED BY NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

Nottinghamshire Healthcare NHS Foundation Trust is under scrutiny at present following the killings and serious assaults by psychotic patient Valdo Calocane. An independent investigation under HSG 94-27 under NHS England's auspices, is expected. NHS England has in the meantime asked all ICBs (service commissioners) to review how they commission mental health intensive support services such as Assertive Outreach services. Such services were previously depleted when the 1999 mental health National Service Framework standards were abandoned and commissioners were permitted to stop purchasing some specialist services, alongside comparatively greater defunding of mental health services. See funding pattern changes in the CMO report on mental health 2013:

Sally Davies CMO report on mental health 2013

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> More recently, NHS England and Monitor have imposed a 'tariff deflator', which is a fifth higher in 2014/15 for mental health and community organisations than for their acute counterparts[26] (see: www.england.nhs.uk/wp-content/uploads/2013/12/cquin-guid-1415.pdf). This tariff differential does not seem to be aligned with the overall 'parity of esteem' policy direction.

Alongside the funding changes, mental health hospital beds have continued to be cut, reaching an all-time low of 17,863 by last year, and occupancy levels are dangerously high. Crisis services which have a stated role of supporting patients in the community have sometimes strayed beyond this remit, to become active blocks to dwindling hospital beds, even when clinically needed. This is reflected in coroners' findings.

See an up-to-date analysis by Hundred Families (a charity which supports the families of those killed by mentally disordered people and campaigns for safer services) of chaotic emergency mental health bed shortage,:

NOT ENOUGH BEDS? An analysis of the provision of emergency psychiatric beds by Clinical Commissioning Groups in England and Health Boards in Wales under Section 140 of the Mental Health Act 1983

I have searched the Chief Coroner's database on published Prevention of Future Deaths warning reports that relates to Nottinghamshire Healthcare NHSFT, as one of the indicators of pressure on services.

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A total of 26 coroners' Prevention of Future Deaths (PFD) warning reports were found published on the Chief Coroner's website, dating back to 2014, which raised concerns about services provided by Nottinghamshire Healthcare NHSFT. This does not necessarily represent all PFDs that have been issued regarding the trust in this period. Occasionally, for whatever reasons, a PFD report may not be published.*

PFD warning reports are issued only exceptionally by coroners when there is serious concern about the risk of future deaths.

The 26 published PFDs covered in addition to the trust's core business of mental health services, its community paediatric service and its provision of healthcare in prisons.

The trust provides primary healthcare, mental health care and substance misuse services to several prisons. According to Care Quality Commission data, the trust currently services HMP Ranby, HMP Lowdham Grange, HMP Nottingham, HMP Lincoln, HMP North Sea Camp, HMP Morton Hall (previously an immigration removal centre, which the trust also serviced). Trust data shows that the trust previously also serviced HMP Leicester, after an approach by NHS England in 2018. CQC data showed that the trust also previously serviced HMP Gartree.

Prisoners are a particularly marginalised group with higher risks involved in their care, so service failures are especially significant. Widespread healthcare coverage of prisons by a trust with recurring risk management failures presents a concern.

There are recurring concerns raised in the 26 PFDs by coroners. These included failures of risk management, disorderly discharges from hospital and from community team caseloads, failures to provide appropriate care, post hoc alteration of patient records and poor incident reviews which sometimes failed to identify (or disclose) key errors by

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* **Discrepancies about number of PFDs:**

I found 3 published Nottinghamshire Healthcare PFDs for the year 2016, but the following trust FOI disclosure from the What Do They Know site indicates that the coroner issued 4 PFDs that year:

Nottinghamshire Healthcare NHSFT FOI disclosure 13 June 2024 ref 9840

Similarly, I found 7 published PFDs for 2023 but this trust FOI response indicates that there were 8 PFDs.

The trust FOI wrongly stated that there were only 2 PFDs in 2015, but I found 3 published for that year.

This FOI response also indicated that there were an additional PFD in 2014 that I did not find published on the Chief Coroner's database.

the trust. On one occasion, the coroner explicitly determined that the trust had not fully discharged its Duty of Candour.

The indications of poor governance are of concern given that a trust misconduct investigation was launched last year into allegations of staff falsifying records about inpatient observations, as well as mistreatment of patients, with a number of staff dismissed as a result.

Relevant to these issues, one 2023 PFD found that a patient died after failures of staff observation which were partly due to staff being distracted with their mobile phones:

" *There was inadequate monitoring of Michelle by staff tasked with performing 2:1 eyesight observations, as staff were distracted by the use of their personal mobile telephones, an activity which was prohibited on the ward."*

There were three PFD cases in which the coroner found failures of care by the trust amounting to neglect. All three neglectful deaths engaged Article 2: they comprised one patient detained in high secure services and two patients in the prisons.

The coroner also concluded that trust Crisis services saw their sole role as preventing access to hospital beds, instead of protecting life: "*The approach of the Crisis Resolution Home Treatment Team of considering their role to be limited to avoiding the need for patients to receive inpatient treatment. The primary role of any medical professional ought to be the protection of life, but within the written and oral evidence from the CRHTT the focus was on prevention of hospital admission alone*"

This is the broad breakdown of the published PFDs by year:

2024 – 5 PFDs
2023 – 7 PFDs
2022 – 2 PFDs
2021 – 3 PFDs
2017 – 2 PFDs
2016 – 3 PFDs
2015 – 3 PFDs
2014 - 1 PFD

The PFDs are listed in the table below by year, most recent first, with links to the PFD reports.

Minh Alexander 26 January 2025

The results of my search of the Chief Coroner's database are as follows:

YEAR	DECEASED'S NAME, CORONER'S REFERENCE NUMBER & LINK TO THE PFD REPORT	BRIEF SUMMARY
2024 **(5 PFDs)**	Tammy WATKINS Ref. 2024-0017 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/tammy-watkins-prevention-of-future-deaths-report-2024-0017_published.pdf	Death by bowel perforation. Failures to manage risk (ingestion of foreign bodies) and failures of physical healthcare amounting to neglect
	Kenneth BAYLIS Ref 2024-0117 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/kenneth-baylis-prevention-of-future-deaths-report-2024-0117_published.pdf	Failure to manage inpatient suicide risk including not involving family, and inadequate incident review
	Alexander LYALUSHKO Ref.2024- 0449 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/alexander-lyalushko-prevention-of-future-deaths-report-2024-0449.pdf	Failure to respond to GP's referral, which was followed by patient's suicide. Inadequate incident review which omitted the failure to respond to the GP referral.
	Daniel TUCKER Ref.2024-0115 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/daniel-tucker-prevention-of-future-deaths-report-2024-0115_published.pdf	Jury inquest which found multiple failures of care, including not involving family, leading to self-inflicted death after a confused, inappropriate discharge from psychiatric hospital.
	James SOUTHERN Ref 2024-0529 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/james-southern-prevention-of-future-deaths-report-2024-0529.pdf	Failure to follow up a patient with failure to allocate a care coordinator, followed by death in the community from drug overdose. Care records amended after patient's death.
2023 **(7 PFDs)**	Andrew VIZARD Ref. 2023-0273 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/andrew-vizard-	Poor emergency physical care for a detained inpatient, with inaccurate claims in the incident report

	prevention-of-future-deaths-report-2023-0273_published.pdf	that staff reacted immediately, when they did not
	Christopher SMITH Ref 2023-0420 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/christopher-smith-prevention-of-future-deaths-report-2023-0420_published.pdf	Poor prison healthcare amounting to neglect. Death from pulmonary embolism and cardiac arrest at age 35.
	Gerard MURRAY Ref 2023-0391 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/gerard-murray-prevention-of-future-deaths-report-2023-0391_published.pdf	Poor inpatient suicide risk management and failure to involve family
	Jonathan ("Jonny") COLE Ref 2023-0186 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/jonathan-cole-prevention-of-future-deaths-report-2023-0186_published.pdf	Poor management of PTSD and suicide risk both by the armed services and by the trust. Inadequate incident review by the trust with an explicit criticism by the coroner that the trust had not fully discharged its duty of candour
	Mark BERESFORD Ref 2024-0577 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/mark-beresford-prevention-of-future-deaths-report-2024-0577.pdf	Death by hanging. Poor prison healthcare, failure of clinical assessment of mental state, discharge from mental health services without appropriate reference to the MDT, failure to apply Safer Custody procedures appropriately
	Thomas JAYAMAHA Ref 2023 -0116 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/thomas-jayamaha-prevention-of-future-deaths-report-2023-0116_published-2.pdf	Suicide in the context of complex needs not being accommodated and unsatisfactory trust incident report. Coroner unsatisfied that trust remedial measures were in place.
	Michelle WHITEHEAD Ref 2023-0370 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/michelle-	Death of a detained inpatient after failure to manage physical deterioration due to

	whitehead-prevention-of-future-deaths-report-2023-0370_published.pdf (See also a preliminary PFD issued in 2022 on this case: https://minhalexander.wordpress.com/wp-content/uploads/2025/01/michelle-whitehead-prevention-of-future-deaths-report-2022-0016_published-1.pdf)	psychogenic polydipsia and to properly implement the rapid tranquillisation policy. Included failure to maintain 2:1 eyesight observations because staff were distracted by mobile phones (prohibited in theory).
2022 **(2 PFDS)**	Alexander BRAUND Ref.2022-0407 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/alexander-braund-prevention-of-future-deaths-report-2022-0407_published.pdf	Jury inquest. Poor prison healthcare amounting to neglect and apparent alteration of records. Died aged 25 of atypical pneumonitis leading to cardiac arrest and hypoxic brain injury.
	Keith NOTTLE Ref 2022-0189 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/keith-nottle-prevention-of-future-deaths-report-2022-0189_published.pdf	Death by overdose following discharge from mental health services without consultation or communication with patient and GP. "Recalcitrance" by the trust in response to repeated requests for specialist care to be resumed. Inappropriate gatekeeping functions by unqualified trust telephone workers not consistent with trust procedure.
2021 **(3 PFDs)**	Paul BARTON Ref 2021-0338 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/paul-barton-prevention-of-future-deaths-report-2021-0338_published.pdf	Death by hanging after repeated self harm, with failures of risk assessment. Coroner considered Crisis service believed its role to be primarily one of preventing admission to hospital, instead of protecting life. Coroner very dissatisfied with trust incident report *"it included many false and inaccurate statements, failed to*

		challenge false assumptions made at the time and introduced new false information which was not taken from any available records. It caused distress to the family…"
	Sean FEGAN Ref. 2021-0083 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/sean-fegan-2021-0083-redacted.pdf	Inappropriate discharge without justification and despite care plan recommendations by a specialist nurse and consultant psychiatrist. Family "rebuffed".
	Patricia FERGUSON Ref 2021- 0155 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/patricia-ferguson-2020-0155.pdf	Suicide in the context of unmet need for psychology input. Coroner criticised insufficient purchasing of psychology capacity by service commissioners.
2017 **(2 PFDs)**	Michael DREWRY Ref 2017-0386 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/michael-drewry-2017-0386_redacted.pdf	Death in the community due to self-administered ligature. Coroner criticised quality of care by Crisis service, including failure to escalate to senior staff.
	Ryan VOUT Ref 2017-0376 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/ryan-vout-2017-0376_redacted.pdf	Jury inquest. Self-inflicted stab wound whilst floridly psychotic, nine days after discharge from a three month inpatient episode. Poorly coordinated discharge with no family involvement.
2016 **(3 PFDs)**	Rohid SHERGILL Ref 2016-0364 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/shergill-2016-0364.pdf	Death of child treated by trust paediatric nurse by aspiration pneumonitis, after failure to test whether a nasogastric tube had been correctly sited. Coroner determined that the NGT had been wrongly inserted in lungs
	Steven MAY Ref 2016-0109	Death by hanging of a mentally disturbed prisoner. Poor prison healthcare and

	https://minhalexander.wordpress.com/wp-content/uploads/2025/01/may-2016-0109.pdf	failures of Safer Custody procedure and first aid
	Phillip DENNING Ref 2016-0058 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/denning-2016-0058.pdf	Unsafe discharge from outpatient care without the patient or the GP being informed, followed by death by overdose. Coroner concerned about lack of service integration for patients with substance misuse co-morbid with other disorders.
2015 **(3 PFDs)**	John LOWE Ref 2015-0132 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/lowe-2015-0132.pdf	Death following poor management of falls risk in a mental health inpatient.
	Glenda DAY Ref 2015-0410 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/day-2015-0410.pdf	Multiple failures of inpatient suicide risk management followed by death on leave (despite the family's concerns about leave being granted) from an overdose. Coroner concerned about insufficient trust learning.
	Paul HARDY Ref 2015-0041 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/hardy-2015-0041.pdf	Poor prison healthcare for cancer with delays and failures to adhere to guidelines. It did not cause death but caused needless suffering and distress.
2014 **(1 PFD)**	John STABLER Ref 2014-0552 https://minhalexander.wordpress.com/wp-content/uploads/2025/01/stabler-2014-0552.pdf	Jury inquest, self-inflicted death by hanging. Coroner raised a concern about lack of access to medical records in the reception suites at the relevant prisons.

There was a linked PFD issued in 2021 on a Nottinghamshire Healthcare patient, Philippa Day, who died by an overdose of insulin. The coroner raised concerns about the DWP's role in the stress experienced by vulnerable, disabled people. There was no criticism made of the care by the trust. For completeness, I provide the PFD:

Philippa Day PFD, Coroner's Ref 2021-0043

Similarly, another PFD was issued in 2024 on a patient at HMP Gartree who died by hanging at a time when Nottinghamshire Healthcare NHSFT was providing the healthcare for the prison (October 2022). The coroner made no criticism of the trust and the PFD relates to concerns about custodial staff. For completeness, this is the PFD report:

Stephen Sleaford coroner's PFD Ref 2024-0550