

THE NOTTINGHAM INQUIRY

St. No: WITN0495001

Name: Máirín Casey

Date: 4th September 2026

FIRST WITNESS STATEMENT OF MÁIRÍN CASEY

HM SENIOR CORONER FOR NOTTINGHAM AND NOTTINGHAMSHIRE

I, Máirín Casey, the Senior Coroner for Nottingham and Nottinghamshire, will say as follows:

Introduction

1. This witness statement is provided to assist the Nottingham Inquiry (the “Inquiry”) with the matters set out in the Rule 9 Request dated 7th July 2026 (the “Request”).
2. I was called to the Bar of England and Wales in 1989. I was appointed Assistant Deputy Coroner for Louth and Spilsby in Lincolnshire in 2005. I was appointed as Assistant Deputy Coroner Nottingham and Nottinghamshire in 2009, and in 2011 I was appointed to the post of Senior Coroner for Nottingham and Nottinghamshire.
3. As I sit in judicial office, it is inappropriate for me to express any views or opinions regarding evidence given to the Inquiry by others, or in relation to any other matters within the Inquiry’s terms of reference. I can however assist the Inquiry by providing a factual account addressing the specific matters of fact set out in the Request.

Prevention of future death reports

4. I have been asked to explain the process for raising prevention of future death reports to an NHS Trust, including the circumstances in which they will be raised and the actions that are expected to be taken in response to them.
5. The process of issuing and responding to a report to prevent future deaths (or ‘PFD report’), whether in respect of an NHS Trust or any other person or organisation, is laid down by statute in schedule 5 para 7(1) Coroners and Justice Act 2009 and Regs 28 and 29 of the Coroners (Investigations) Regulations 2013. The process is also

covered by formal non-statutory Guidance to coroners issued by successive Chief Coroners.

6. The Inquiry is referred to these primary sources for a full account of how and when PFD reports will be issued and the response process that then follows: -

Coroners and Justice Act 2009 schedule 5 para 7(1) [WITN0495002]

Coroners (Investigations) Regulations 2013, regs 28 and 29 [WITN0495003]

Chief Coroners Guidance for Coroners on the Bench, Jan 2025 Ch.16

[WITN0495004]

Chief Coroners Guidance 5: PFD reports, Jan 2016 (*now superseded*)

[WITN0495005]

7. All PFD reports issued and any responses to them are published in accordance with the Chief Coroners' publication policy on the Courts and Tribunals Judiciary Website. Reports issued can also be tracked on the 'Preventable deaths tracker' which allows for tracking of PFD reports by coroner area and addressee: -

Reports to Prevent Future Deaths (PFD reports) [WITN0495006]

Chief Coroners' Publication Policy 2026 [WITN0495007]

Preventable deaths tracker [WITN0495008]

8. In summary, a Coroner is under a statutory duty to report a concern about the practice of an NHS Trust (or any person or organisation) if something revealed by a coronial investigation (including evidence at the inquest) gives rise to a concern that circumstances creating a risk of further deaths will occur, or will continue to exist, in the future, and, in the coroner's opinion, action should be taken to prevent those circumstances happening again or to reduce the risk of death. If the concern has fully formed and there is a belief on the part of the coroner that action should be taken, then a PFD report must be issued.
9. It is important to note that a coroner only has power to issue a report to a person or entity who might be able to take action. A coroner may not make any recommendation about what that action should be, nor can a coroner require any action to be taken.
10. I have provided a list of all 33 PFD reports issued by my coronial jurisdiction directed at the NHFT in the past ten years. [WITN0495009]. I am not aware of any others. Copies of those reports and any response received from NHFT are appended. [WITN0495010-WITN0495069]

Other ways to raise concerns.

11. I have been asked to explain the processes in place for raising concerns about practice at an NHS Trust, otherwise than by way of a PFD report.
12. Normally the investigation will be complete, with the inquest concluded, before any PFD report is issued. However, on rare occasions, it is deemed necessary to issue a PFD before an inquest hearing has concluded.
13. Coronial concerns will often start to take shape at an early stage of the investigation. On other occasions, concerns may begin to unfold during the course of hearing oral evidence during an inquest hearing.
14. Potential concerns, that have not yet crystallised, if identified *prior* to an inquest hearing, will often be raised as issues with the relevant Interested Person in the inquest at a Pre-Inquest Review Hearing. The Interested Person will very often be given an opportunity to provide further evidence to the coroner regarding any steps they, or their organisation, have already taken to address the matters that may give rise to a concern.
15. Should concerns begin to form *during* an inquest hearing, then similarly, these embryonic concerns may again be raised with the relevant Interested Person, and there may be opportunity given for a witness statement to be provided and/or a further live witness called to address the relevant matters before the inquest evidence closes.
16. If this evidence reveals that action has already been taken such that the coroner is reassured that the risk of death they perceived has already been addressed, then the concern does not crystallise and the duty to send a report is not realised. A PFD report will not be issued in such cases.
17. At times, the coroner may be aware of previous inquests where the same or similar concerns were identified. The coroner may even reference previous PFD reports at an inquest where the concern has said to have been addressed in a response to an earlier PFD report, yet same issues arise again. In such cases if the events occurred after the initial PFD report was sent, then a further PFD report will likely be issued due to the continuation of a concern in the same area, unless fresh remedial action has already been taken that has now fully addressed the risk to life.
18. An alternative way of addressing a coronial concern is to send a letter instead of a PFD report. This was a step proposed by an earlier Chief Coroner, HHJ Peter Thornton

KC, after he adopted this procedure (when he wrote to the Metropolitan Police Commissioner re police vetting procedures) having presided over an inquest in 2009. However, as is made clear in the current Chief Coroner's Guidance (*at Ch 16 §48*) this is a step taken in exceptional circumstances and only where the statutory duty to make a PFD report does not arise, but the coroner nevertheless wishes to draw someone's attention to a matter of concern. This will be the situation where the matter of concern does not impact on the risk of future deaths, and so the duty to make a PFD report has not arisen. The coroner might then write a letter bringing the matter to the attention of the relevant person or organisation.

19. This practice is only very rarely adopted in the Nottingham jurisdiction. I am aware of one example in the past few years in respect of NHFT. An Assistant Coroner raised some matters in an open letter to the Trust and other public bodies; the letter is dated 19 May 2022 [WITN0495070] and followed the inquest into the death of Ms Crowder.¹ NHFT responded to that letter on 1 August 2022 [WITN0495071] (both documents are appended).

Meetings with NHFT executives

20. I have been informed that evidence provided to the Inquiry by NHFT describes meetings between myself (and other coroners) with NHFT executives. I have been asked to give more information about these meetings.
21. The efficient running of the coronial service requires collaborative working arrangements with a number of public bodies. During my tenure as Senior Coroner, I have held meetings with executives from all the NHS Trusts in my jurisdiction, as well as those responsible for running HM Prisons in the area, the Medical Examiner service, the Nottinghamshire Police, those running mortuary services, local funeral directors and faith groups. Coroners and Coroners Officers from the Nottingham Coroner's Service have also, on occasions, delivered training to these stakeholders. I have also had occasional meetings with the local judiciary – the Designated Family Judge and the Criminal judges.
22. In respect of NHS Trusts in particular, I have engaged with all of the local NHS Trusts in relation to case preparation and our service's expectations of how they could and should assist the coroner with matters such as: identifying relevant staff involved in a death; the provision and redaction of medical records; the provision of medical

¹ Note: names of deceased NHFT patients are contained in this statement where their death has already been the subject to an Inquest held in public, and relevant PFD reports flowing from their deaths are also publicly available.

reports; the provision of internal investigation reports; and the provision of witness statements to the coroner's service. Ad hoc meetings are organised to ensure that wherever possible we can assist one another with case progression, information sharing and that we are following agreed protocols and develop local protocols where this is considered to be mutually beneficial. I have attended meetings with NHFT where we have also discussed the NHFT's internal review mechanisms, and how and when information will be passed on to the coroner from those internal processes.

23. There is no formal timetable for meetings, rather meetings with NHFT occurred on an *ad hoc* basis, usually one or two meetings with NFHT a year. To the best of my knowledge, I met with representatives of NFHT in person or via teams on eight occasions since 2020 on the following dates: 7/2/2020, 8/7/2021, 16/12/2021, 31/3/2022, 8/9/2022, 3/2/2023, 17/4/2024, 7/2/2025.
24. I note that in one of the NHFT documents provided to me by the Inquiry [NHNB0012321_0003] it is suggested there is a "quarterly meeting" with the coroner. There is not and never has been a timetable of quarterly meetings with coroners. However, my Senior Coroner's Officer does hold purely administrative meetings between two to three times a year with those NHFT staff who complete administrative tasks in respect of inquests where individual case progression will be discussed (i.e. implementing coronial directions re matters such as provision of a deceased's medical records or obtaining witness statements).
25. The purpose of *ad hoc* meetings between coroners and NHFT is to facilitate general discussions about process and collaborative working. The meetings never address issues relating to open investigations/inquests, as these matters can only be dealt with at a public inquest hearing.
26. I met (by MS Teams) Ms Helen Collins an Independent Safety Specialist/Senior Nurse from Surrey Heartlands NHS Trust on 5 October 2023. Ms Collins had been commissioned by NHFT to provide an overview of PFD Reports issued to NHFT. Ms Collins provided information to me (and Assistant Coroner, Dr Didock who also attended that meeting) about the Patient Safety Incident Response Framework (or 'PSIRF') that had recently been introduced by the NHS England addressing responding proportionately to patient safety incidents.
27. None of these meetings were formally minuted by me, and I do not now have a clear recollection of any detail from any particular meeting, although I am able to recall these meetings in broad outline. The topics covered have included:

- a. Liaison re key personnel to ensure collaborative working and effective case management.
- b. Where there were changes of personnel, there were meetings to introduce these individuals e.g. changes of office manager at our service, change of the Head of the Legal Team at NHFT.
- c. Trust explaining their general timeframes both for obtaining statements and investigation reports. NHFT offering explanations for their delays in filing evidence. Addressing evidence sharing with the bereaved.
- d. NHFT explaining changes to methodology of their internal investigations both in terms of how those investigations were categorised e.g. Concise investigations/ SI reports, PSIRF, how bereaved families would be involved and information sharing re concerns of the bereaved between my office and the Trust.
- e. One issue I perceived and passed on to the NHFT was that the bereaved family were not always involved in the post death review process, particularly for concise investigations.
- f. At some of these meetings the NHFT has passed on information to me regarding internal review processes and their own analysis of themes arising from cumulative PFD reports issued by the Nottingham Coroners.

28. As these meetings address general matters of process and information sharing, they also provide an opportunity for the Trust to share information with us when the NHFT had identified themes and/or proposed to take steps within their organisation to address concerns already raised in PFDs.

29. Coronial concerns about matters arising in individual cases that gave rise to a risk of future deaths would always be set out in a PFD report and follow the statutory PFD process.

July 2021 meeting

30. I have been provided by the Inquiry with the report prepared for NHFT's Quality Operational Group meeting on 02.08.21 Inquests Learning (in respect of open and closed inquest for the period 01.01.21 – 30.06.21) [NHN0019232] which refers to a meeting with the NHFT that I attended (with two Assistant Coroners) on 8 July 2021 (a briefing note for a follow up meeting in December 2021 [WITN0356017] also appears to contain a note of the July 2021 meeting).

31. I have noted the key themes said to have been raised during the 2021 discussion which included: Family involvement (in the patient's care, and in the serious incident review process); lack of awareness of Triangle of Care and limited implementation of

the principles; delay in preparing an action plan following a serious incident investigation until the week of the inquest; lack of risk assessment documentation on RiO; Limited communication between inpatient and community services.

32. Whilst I cannot recall the detail of this meeting held over 5 years ago, I have no reason to think that the document does not accurately capture the matters that were raised at this meeting. The issue of the family involvement in care, family involvement in post death investigations; the quality of risk assessment and communication between inpatient and community services were all matters that had been raised in PFD reports addressed to NHFT. There has been a total of 33 PFD Reports directed at NHFT over the last 10 years. These PFD reports and NHFT's responses are appended to this statement. [WITN0495010-WITN0495069]

Triangle of care

33. I have been asked by the Inquiry to explain the 'Triangle of Care' and its principles.
34. The 'Triangle of Care' is a term used to describe the concept that during a person's treatment journey there should be a three-way therapeutic collaboration between health professionals, the patient and their carers or family. It recognises the essential role that carers and their family play in a person's treatment journey and the way in which they can support recovery.
35. The specific nature of the coronial concerns about this area would have been set out in the PFD reports at the relevant time. The appended PFD reports following the inquest into the deaths of Mr Gerard Murray in July 2022 [WITN0495028-WITN0495029] and Mr Kenneth Baylis in January 2023. [WITN0495024-WITN0495025]

December 2021 meeting

36. I have been asked whether the meeting on 16.12.21 [foreshadowed in WITN0356017], to follow up on issues raised at the July 2021 meeting, occurred. I can confirm the meeting took place although I have no reliable memory of that meeting.

Learning from inquests report

37. I have been asked to comment upon a report prepared for a NHFT Trust Board meeting on 1 March 2022, titled 'Learning from Inquests' (in respect of inquests in the period 01.09.21 – 28.02.22) [NHNB0012321]. This includes a number of areas of concern either raised by a coroner or identified by NHFT from examining inquests that were in their domain.
38. Having reviewed the 33 PFD reports [WITN0495010-WITN0495069] issued to NHFT by the Nottingham Coroners service in the past ten years, and the responses received from the Trust to them, it appears to me that this report has accurately identified the key themes being raised in the PFD reports. However, given I sit in Judicial office it would not be appropriate for me to take up the Inquiry's invitation to comment upon or provide my opinion of the steps taken in response to PFD Reports by the NHFT.

March 2022 meeting

39. I have been provided with notes from a meeting on 31.03.22 [WITN0354116] attended by me at which I raised questions regarding the NHFT's responsibility in relation to care provided by other agencies, in circumstances where there were significant concerns about the provision of care by others. The note mentions the coroner's concerns about NCHT patients cared for at The Priory, Arnold.
40. There had been a PFD Report issued by an Assistant Coroner on 8 December 2021 (directed to Heathcotes Group but also copied to NHFT) following the inquest into the death of Rebecca Begg at Heathcotes, Moorgreen. Ms Begg had been transferred from a Priory hospital shortly before her death. An inquest into the death of another patient at the Priory hospital, held in November 2021, had also identified concerns about the care provided at the Priory and returned a conclusion of neglect, although the PFD reporting duty had not been deemed to be triggered in that case. My recollection is that around this time, the Priory Unit had been rated as 'Inadequate' by the CQC and in the light of this, the Trust set out its plans for ensuring that future patients received safe and appropriate care where the Priory were involved. However, I cannot now recall the detail beyond this note of the meeting.

Final remarks on the r.9 Request

41. I have been referred to the evidence that a number of NHFT witness have given to the Inquiry and I have been asked to give my view of the adequacy of the actions that

were taken to address the concerns being raised by myself and the Assistant Coroners in PFD reports, and whether I consider the steps taken by NHFT were sufficient to address those concerns. I have been asked to suggest improvements that could be made locally and nationally to multi agency working to increase effectiveness in preventing similar outcomes in the future. I have also been invited to express my own view as to the recommendations that I think the Chair of this Inquiry should make to ensure lessons are learned and to prevent similar attacks in the future.

42. I am unable to offer any opinion in respect of these matters. Given my position as an independent judicial officer, I consider it would be inappropriate for me to do so.

43. Parliament, via s.10 the Coroners and Justice Act 2009, has expressly prohibited all coroners from expressing any opinion on any matter beyond the statutory questions in s.5 Coroners and Justice Act 2009: who a deceased person was and when, where and how they came by their death. The ancillary power under schedule 5 para 7(1) Coroners and Justice Act 2009 and Regs 28 and 29 of the Coroners (Investigations) Regulations 2013 to make a report to prevent future deaths is just that: a power to report. A coroner may neither make recommendations nor suggest, still less require, that action should be taken, let alone mandate any particular action. A coroner has no power to act if the recipient declines to take action, or if the response to a PFD report is inadequate or vague. A coroner who requested further steps after receiving a response they considered inadequate would exceed their powers.

44. As the Chief Coroners Guidance makes clear (Ch 16 §24j): “Coroners should not make any other observations of any kind, however well intentioned, outside the scope of the [PFD] report. Such expression of opinion is impermissible under section 5(3) of the 2009 Act”.

45. I have sought the advice of Counsel who has assisted me when writing this statement.

Statement of truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

GRO-B

Signed:

Name: Máirín Casey, HM Senior Coroner for Nottingham & Nottinghamshire

Dated: 4th September 2026

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No.	Inquiry URN	Document Description
1	WITN0495002	Coroners and Justice Act 2009 schedule 5 para 7(1)
2	WITN0495003	Coroners (Investigations) Regulations 2013, regs 28 and 29
3	WITN0495004	Chief Coroners Guidance for Coroners on the Bench, Jan 2025 Ch.16
4	WITN0495005	Chief Coroners Guidance 5: PFD reports, Jan 2016 (<i>now superseded</i>)
5	WITN0495006	Courts and Tribunals Judiciary website - Reports to Prevent Future Deaths (PFD reports)
6	WITN0495007	Chief Coroners' Publication Policy 2026
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69	NHNB0012321	Nottinghamshire Healthcare NHS Foundation Trust Board meeting paper titled 'Learning from Inquests', dated 01/03/2022
70	NHNB0019232	Nottinghamshire Healthcare NHS Foundation Trust Quality Operational Group meeting paper titled 'Inquests Learning', dated 02/09/2021
71	WITN0356017	Email from Samantha Eagling to Anne-Maria Newham, Susan Elcock and others re Notes from the Senior Coroner Meeting, dated 01/04/2022
72	WITN0354116	Briefing notes for Anne-Maria Newham, Sue Elcock and Samantha Eagling in preparation for meeting with Senior Coroner, 16/12/2021