NHS England

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National Medical Director
NHS England
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10 August 2022

Dear Mr Broadbridge,

Re: Regulation 28 Report to Prevent Future Deaths – Zoe Emma Zaremba who died on 21 June 2020.

Thank you for your Report to Prevent Future Deaths (hereafter “Report”) dated 25 April 2022 concerning the death of Zoe Emma Zaremba on 21 June 2020. I would like to express my deep condolences to Zoe’s family.

Following the inquest, you raised concerns in your Report regarding the care she received following her diagnosis of Asperger’s Syndrome and during her complex mental health condition.

We can see that this case raises very concerning issues about gaps in care for a vulnerable autistic young woman suffering with complex mental health. The report highlights how important it is that, when autistic people access mental health services, there is high quality care tailored to individual needs. Care should be reasonably adjusted and delivered by staff who have knowledge and awareness of autism, including an understanding of how best to respond to women with a history of trauma.

In the context of the NHS Long Term Plan, initiatives have been undertaken by NHS England that are of relevance to the issues raised following Zoe’s death. This includes one off funding made in 2021/2022 for future improvements, to include:

- £7 million for local areas to test ways to improve the quality of autism diagnostic pathways. This funding supported a wide range of projects that tested new ways to support people and their families through the autism diagnostic pathway (39 projects for children and young people and 25 projects for adults: a total of 64 one-off projects). The projects are still underway, and outcomes are expected to be reported to the programme later this year and into early 2023. We will use the learning from these projects along with any available research to inform guidance/ support for local systems on how to improve the quality and access to autism diagnostic assessments including pre and post diagnostic support
- £1.5 million supported autism training for staff working in adult mental health inpatient settings.

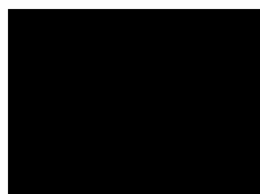
- £4 million for a range of projects across the country to improve the sensory environment of mental health hospitals. There were 40 projects across the country aimed at environmental changes to accommodate sensory needs of autistic people in mental health inpatient settings. The projects delivered changes to the physical environment and/or training for staff on the sensory needs of autistic people and/ or learning from the experiences of patients.
- We are developing an updated Care (Education) and Treatment Review (C(E)TR) policy. The new published policy will include a requirement for people with a learning disability and autistic people in a mental health hospital to have a C(E)TR take place where there is a proposal to remove a diagnosis of autism or learning disability for a person.

The University of Reading were also been asked to develop a sensory assessment tool for use in mental health hospitals and we commissioned the National Development Team for Inclusion (NDTi) to develop Ten Sensory Friendly Ward Principles as part of the "It's Not Rocket Science" work; see here for details. The Ten Principles are focused on the, often quite small, changes needed to ward environments to improve the sensory environment for autistic people. The principles were used to inform the development and delivery of the sensory projects programme in 2021/2022 so that projects had to demonstrate how the principles were used. We are currently developing a sensory friendly resource pack for health Trusts and Integrated Care Systems (ICSs).

We have also reviewed the Regulation 28 Report response from Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), who were responsible for Zoe's care, outlining the actions they are implementing following the concerns raised by Zoe's case. We note the changes and improvement to training, risk assessment and holistic care, as well as the commitment to review all of their patients currently with an Autism marker and a diagnosis of Emotionally Unstable Personality Disorder (EUPD). We also welcome the intention for better collaboration and communication between mental health services as a result of the changes to the commissioning model supported by the newly created Integrated Care System for Humber & North Yorkshire. We hope this provides further assurance around the steps being taken, following the concerns raised around Zoe's care in the Report.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



National Medical Director