Professor [redacted]
National Medical Director
Skipton House
80 London Road
SE1 6LH

Ms Emma Serrano
Assistant Coroner, Derby and Derbyshire Area
St Katherine's House
St Mary's Wharf
Mansfield Road
Derby
DE1 3TQ

[redacted]

18th June 2021

Dear Ms Serrano,

Re: Regulation 28 Report to Prevent Future Deaths – David Ball

Thank you for your Regulation 28 Report (from hereon, 'report') dated 24 November 2020 concerning the death of David Ball on 1 June 2018. Firstly, I would like to express my deep condolences to Mr Ball's family. Secondly, I am sorry that it has taken so long to respond to this report.

The regulation 28 report concludes Mr Ball's death was a result of Methadone and Venlafaxine misuse.

Following the inquest you raised concerns in your report to NHS England and NHS Improvement (NHS E/I) that his death was contributed to by a discharge care plan, put in place on his discharge from an informal inpatient stay in the Hartington Unit on the 1st June 2018. Your concerns suggest that the discharge plan was not fully implemented by the community mental health teams. You further highlighted concerns that different healthcare departments have different patient care records and that departments did not communicate with one another. You pointed out that professionals would have to rely on 'professional curiosity' in order to ascertain crucial information regarding their patients. Furthermore, the providers involved in the final days and weeks of this Mr Ball's journey all had different care records which contributed to the communication challenges.

We are deeply saddened by the tragic death of Mr Ball and have taken this matter extremely seriously, having reviewed separate Serious Incident reports and statements from all the providers involved in Mr Ball's care.

In addressing your concerns and considering any risks going forward my colleagues in the Midlands Region have undertaken a review of Mr Ball's care and identified actions as follows:

- **Shared Care Record:** a clear plan is in place to bring together a shared care record for Derby and Derbyshire that plans to address the problems where there are multiple healthcare providers involved in a person's care. This work is unlikely to be completed until 2024. In the meantime, there are systems in place to facilitate shared care conversations which include a Mental Health Liaison Team who will share relevant details on request and where appropriate in line with data protection regulations and a Mental Health Risk Triage Assessment Form, in use at Chesterfield Royal Hospital (CRH). This triage assessment form is designed to prompt the professional completing it to contact the Mental Health Liaison Team where a risk is identified. In Mr Ball's case, it is accepted that this system was impacted by him not providing any history of mental health concerns to the staff at CRH and denying being on any medication;

- **Learning from Deaths:** in the Midlands a Learning from Deaths Forum has been established which brings together Acute, Community and Mental Health Trusts as well as the Regional Medical Examiner. A suitably anonymised case study of Mr Ball's experience has been taken to this forum for consideration, shared awareness and learning. It is accepted that "professional curiosity" or clinical judgement plays a major part in determining health risks and it is unlikely that a system can replace such decision-making which is supported by the significant training medical and nursing staff undertake to carry out their roles. The Forum will be tasked with considering system improvements complimentary to the move to a Shared Care Record and any recommendations will be escalated nationally through NHS E/I's Executive Quality Group and associated sub-group which considers learning and improvement from these matters.

Thank you for bringing this important patient safety issue to our attention and please do not hesitate to contact us if you require any further information.

Yours sincerely,

Professor [redacted]
National Medical Director
NHS England and NHS Improvement