Mr John Broadbridge
Assistant Coroner
North Yorkshire and York Coroner's Court
The Old Courthouse
3 Racecourse Lane
Northallerton
North Yorkshire
DL7 8QZ

**National Medical Director**
NHS England
Wellington House
133-155 Waterloo Road
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SE1 8UG

17 April 2023

Dear Mr Broadbridge

**Re: Regulation 28 Report to Prevent Future Deaths – Antony Christopher McLellan who died on 09 July 2021**

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 05 July 2022 concerning the death of Antony Christopher McLellan on 09 July 2021. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mr McLellan's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Mr McLellan's care have been listened to and reflected upon.

I would like to apologise for the delay in responding to your Report. This was unfortunately due to an administrative oversight during a particularly pressurised time for the NHS, and I would like to offer my sincere apologies to Mr McLellan's friends and family for this as well as assurances that we have reviewed our processes to prevent it from taking place again. I realise that responses to Coroner Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones and appreciate this will have been an incredibly difficult time for them.

Following the inquest, you raised concerns in your Report regarding the fact that the assessment and formulation of risks and safety summary did not fully explore the impact of Mr McLellan's autism, including your concern of a higher level of prevalence of suicide in individuals with an autistic marker both locally and nationally. You considered that urgent solutions were required to prevent further deaths of autistic individuals, especially those with a mental health disorder, by rapidly improving and expanding provisions for assessment and management of risk of harm to themselves.

As of 1 July 2022, all health and social care providers registered with the Care Quality Commission (CQC) must ensure that their staff receive training on learning disabilities and autism appropriate to their role. The training aims to ensure the health and care workforce have the right skills and knowledge to provide safe, compassionate and informed care to autistic people with a learning disability.

The training comes in two tiers:

- Tier 1 for staff who need a general awareness of the support autistic people or people with a learning disability may need;
- Tier 2 is a one-day face-to-face training session for people who many need to provider care and support for autistic people or people with a learning disability or autistic people co-delivered by a trainer and a person with a learning disability and an autistic person.

An eLearning package is the first part of both Tier 1 and Tier 2 and is available through Health Education England (HEE). HEE are building the capacity and capability within ICBs to create a sustainable model. Please see link to FAQs – The Oliver McGowan Mandatory Training on Learning Disability and Autism | Health Education England (hee.nhs.uk)- and e-learning is here: The Oliver McGowan Mandatory Training on Learning Disability and Autism – e learning for healthcare (e-lfh.org.uk)

Your Report highlights the importance of ensuring that there is high quality care tailored to individual needs when mental health services are accessed by autistic individuals. In particular, care should be reasonably adjusted and delivered by multidisciplinary staff, who may be working across inpatient, outpatient and community mental health services, and who have knowledge and awareness of autism. Staff working in acute settings, including psychiatric liaison, the designated place of safety (136 suite), home treatment teams and the crisis line, may require additional specialist training around assessment of mental health and emotional wellbeing in autistic individuals. Linking in with the autism service is key for the mental health services.

In January 2023, NHS England published a new policy with the aim of preventing unnecessary hospital admission for people with a learning disability and autistic people. This includes new guidance on the implementation of dynamic support registers and updates to the Care (Education) and treatment reviews that will help support good practice across mental health inpatient and community services for autistic individuals. The policy can be found here: https://www.england.nhs.uk/publication/dynamic-support-register-and-care-education-and-treatment-review-policy-and-guide/#heading-1.

The NHS Long Term Plan, which is a plan for the future of the NHS, also includes ambitious investment to expand and transform community mental health services for adults and older adults with severe mental illness. From April 2021, all areas are receiving significant additional, ring-fenced funding on a fair-share basis to develop fully integrated primary and community mental health services, that enable people with severe mental illness to have greater choice and control over their care and support them to live well in their communities. By 2023/24, this investment will amount to almost £1billion extra per year for adults and older adults with severe mental illness. Severe mental illness in this context is defined as ‘a range of needs and diagnoses, including psychosis, bipolar disorder, personality disorder, eating disorders, severe depression, and mental health rehabilitation needs – some of which may be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use’. The Long Term Plan also includes a commitment to ensuring that the whole of the NHS works to improve its

understanding of the needs of people with learning disabilities and autistic people, to include increased investment in intensive and community support.

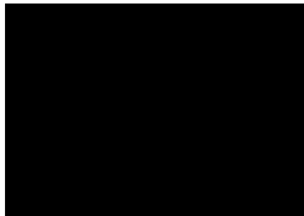
The Humber and North Yorkshire Integrated Care Board (ICB) is the Commissioner that has adopted the contracts which were held by NHS North Yorkshire Clinical Commissioning Group (CCG) and have shared their response with me.

The CCG (and now ICB) commission Tees, Esk, Wear Valley NHS Trust (TEWV) to provide the Mental Health provision to the residents of North Yorkshire. This would be the case whatever the Mental Health condition is and whether that is suspected, being assessed or diagnosed. The contract requires this provision of service. In addition to this where an individual with mental health conditions also has a diagnosis of autism, the contractual expectation would be that TEWV would make reasonable adjustments to their service to ensure that it is delivered to meet the needs of those individuals with autism and a mental health condition.

I would also like to provide further assurances on the national NHSE work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Mr McLellan, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

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