Mr Tom Stoate,
Assistant Coroner for Bedfordshire and Luton,
The Court House,
Woburn Street,
Ampthill,
Bedfordshire,
MK45 2HX

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

[redacted]

[redacted]

18 November 2022

Dear Mr Stoate,

Re: Regulation 28 Report to Prevent Future Deaths – Mr Thomas Antony Smith who died on 30 December 2020

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 16 May 2022 concerning the death of Thomas Antony Smith on 30 December 2020. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Thomas's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Thomas's care have been listened to and reflected upon.

Following the inquest, you raised concerns regarding;

1. Knowledge of the dangers of [redacted] in detained mental health patient settings – including the evidence at the inquest which suggested a lack of knowledge from East London NHS Foundation Trust ("ELFT") staff around [redacted] and it's potentially fatal effects, and the fact that this might be a wider issue of concern, both locally and nationally.

2. The system for assessing risks associated with s.17 leave – in particular, the healthcare assistant in question appears to have been in a position of escorting a patient on leave without knowledge of a patient's very recent potential drug-related presentation, or of a specified intervention aimed at reducing the risk posed to that patient by drugs as set out in his care plan.

NHS England acknowledge and share your concerns regarding knowledge of [redacted] both locally and nationally, although it is not within NHS England's remit to deliver this education as a commissioner. Provider organisations are responsible for providing staff with the relevant training, to ensure that they are aware of issues pertinent to their patient population. In this particular case, ELFT will be responsible for training and refreshing their employees on [redacted] in detained mental health patient settings, and this is addressed further below.

Since 2013, local drug & alcohol services, which are routinely provided by local councils, are able to provide training on 'New Psychoactive Substances' including

[redacted]. In addition, Public Health England ("PHE") previously issued a toolkit for prison staff on New Psychoactive Substances in January 2017, which NHS England was signed up to (Link here). PHE also issued a toolkit for commissioners earlier on in November 2014 (Link here). Both of these toolkits have information that would help healthcare staff to look after individuals who have taken [redacted] and provide advice on how to manage substance use within secure environments, from a clinical, psychosocial and regime perspective. The NHS England Regulation 28 Working Group will ensure that your Report and this response is shared with all regions, to pass onto individual integrated care systems (ICSs) which are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area for further learning and consideration. https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

ELFT have shared their action plan with us relevant to your Report and have been able to facilitate and deliver training to staff on the ward, as well as senior staff within the organisation. They have engaged local drug and alcohol service providers to deliver training and awareness around spice. They have also ensured that staff are aware of the relevant policies, to ensure effective management of patients who are suspected to be intoxicated.

Section 17 Leave is covered by the Mental Health Act 1983 (https://www.legislation.gov.uk/ukpga/1983/20/section/17). With respect to this serious incident, ELFT have revisited the issue of having a robust leave risk assessment prior to a service user accessing leave and have reiterated this to all staff (substantive and temporary) within Luton and Bedfordshire.

All staff members are aware that pre-leave risk assessments must be communicated and agreed by the Nurse in charge prior to leave. Any concerns raised by staff members with regard to pre-leave risk assessments must be communicated to the Nurse in charge. Additionally, if the Nurse in charge identifies that they are not clinically confident with decision making around leave and feels out of their depth, they would be expected to escalate this to their Clinical Nurse Manager or Modern Matron. For out of hours leave, the Duty Senior Nurse (DSN) on site would be able to support with decision making.

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 Thomas, 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,

[redacted]

National Medical Director