NHS England

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National Medical Director
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[redacted]
3 July 2023

Dear Ms Schofield,

Re: Regulation 28 Report to Prevent Future Deaths – Caroline Victoria Forte who died on 20 February 2022

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 11 May 2023 concerning the death of Caroline Forte on 20 February 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Caroline's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Caroline's care have been listened to and reflected upon.

I note that Sussex Partnership NHS Foundation Trust has written a comprehensive response to you reviewing the concerns highlighted by you in a separate Report addressed to them, raising concerns about Caroline's care. It is clear they have reflected upon and taken actions and learnings from the concerns raised. I note that there is now new documentation at the Trust; the '*Record of patient leaving ward'* which staff complete before a patient's Section 17 leave is approved. The completion of the document requires collaborative consideration of the leave safety plan with, not only the patient, but also any relevant family/carer/friend. If the plan lacks any detail this would be identified before the patient leaves the ward and should help avoid any reoccurrence of the issues you have highlighted regarding Caroline's death.

The Trust has also shared with us a helpful learning briefing on Section 17 leave from inpatient wards. This will be shared with the national Regulation 28 Working Group regional representatives for dissemination across the seven NHS regions, to raise awareness of the issue with their Trusts and to encourage best practice.

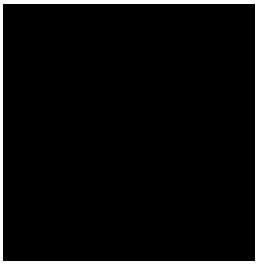
Your concern at the lack of national guidance regarding help and support for families in similar situations to that experienced by Caroline's family has also been raised with NHS England's national Mental Health Team. In 2022, NHS England committed £36m over three years to improve the quality of mental health, learning disabilities and autism inpatient settings. The Mental Health team have advised that these improvements will include developing a culture of care improvement programme which, importantly, is being co-produced with patients, carers, and families with lived experience of mental health illness. The programme, which should come to completion in 2025, addresses the concerns you raise, identifying opportunities to strengthen family/carer voice in patient care, including the risk management of suicide and self-harm and safety planning. This will drive forward improvements in quality and safety

across the board nationally, so that all patients experience excellent and meaningful care.

I would also like to provide further assurances on 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 preventable deaths are shared across the NHS at both a national and regional level and helps us 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,



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National Medical Director