Coroner M E Hassell
Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

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

26 July 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Heather Findlay who died on 11 June 2020.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 12 June 2023 concerning the death of Heather Findlay on 11 June 2020. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Heather's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Heather's care have been listened to and reflected upon.

The concerns in your Report relate to organisational policy at East London Foundation Trust as well as policy within the Metropolitan Police Service. NHS England is not therefore the appropriate organisation to respond to many of the concerns raised.

I do however take the concerns raised seriously, and I thank you for bringing them to my attention, together with the other Reports to Prevent Future Deaths you highlight concerning the care of other patients at the Trust. I have asked that NHS England is sighted on the Trust's response to your Report, as well as the responses to the other cases and we will consider these carefully, to include whether any further action needs to be taken. I have already been sighted on the Trust's Patient Safety Serious Incident Review Report on this matter and note that they have taken a learning to ensure that the police are provided with a direct dial number whenever reporting a patient absconding, which did not happen in this case.

I have also been sighted on the draft Terms of Reference for a new Joint Mental Health and Policing Group in the London region and understand that the first meeting took place earlier in July. I am pleased to see that the group will consider how they work together to deliver the Right Care, Right Person (RCRP) programme (which is a programme to ensure that the right service provides support to people who call the police for mental health matters), together with other mental health programmes and work within the region, and to deliver improvements to ensure safe and effective care for those in mental health crisis, as well as better coordination between the services.

I also draw your attention to NHS England's national Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme, which was established in 2022 to support cultural change and a new model of care across all mental health inpatient settings. The programme seeks to:

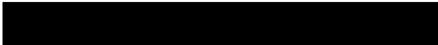
1. Explore and accelerate different therapeutic offers, including community-based alternatives to admission and a culture within inpatient care that is safe, personalised and enables patients and staff to flourish.
2. Have a clear oversight and support structure that is sustainable and transparent, where issues are identified early. Services that are challenged will have timely, effective, and coordinated recovery support.

Your Report has been shared with the team responsible for delivering this programme.

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,



National Medical Director