Ms Penelope Schofield
HM Coroner West Sussex
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National Medical Director
NHS England
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18 August 2023

Dear Ms Schofield

Re: Regulation 28 Report to Prevent Future Deaths – Rachel Kathleen Garrett who died on 29 July 2020.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 27 June 2023 concerning the death of Rachel Garrett on 29 July 2020. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Rachel's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Rachel's care have been listened to and reflected upon.

In your Report you raised the concern that the Mental Health Liaison team involved in Rachel's care could not detain her under Sections 5(2) or 5(4) of the Mental Health Act (MHA) 1983 (Doctors' and Nurses' holding powers), when she attended the Accident & Emergency Department (ED) at Royal County Sussex Hospital during a mental health crisis. This was because the Mental Health Liaison team were employed by Sussex Partnership Foundation Trust (SPFT), while Royal County Sussex Hospital is under the responsibility of an Acute Trust, the University Sussex Hospital NHS Foundation Trust (UHSx). You raised that the Mental Health Liaison team will often have the best knowledge of the patient's health and that the delay in having a busy A&E doctor, with no prior knowledge of the patient's health, act to detain a patient could put future patients at risk.

All systems (partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for health services across geographical areas) must ensure that there are clear pathways for mental health patients who are accessing care via EDs and who need to remain in acute hospital settings until their care can be transferred. This should be supported by access to 24/7 mental health liaison teams (or other age-appropriate equivalents for children and young people), both in Accident & Emergency settings, and on the wards.

The NHS is on track to deliver on its commitment, set out in in the NHS Mental Health Implementation Plan 2019/20 – 2023/24, that all general hospitals will have mental health liaison services by April 2023/24, with 70% meeting the 'Core 24' service standard for adults and older adults or an approved alternative model. The Plan also set out requirements for all acute hospitals to have mental health liaison services that can meet the specific needs people for all ages. For the first time, in 2023, all ED sites

are now offering access to a liaison service or access to local crisis support (via in-reach) on a 24/7 basis. This is up from 66% at 2018, and only 39% back in 2016.

It is not within the remit of NHS England to manage how MHA powers are administered or delegated within Trusts or systems. Some Acute Trusts will provide mental health liaison teams with honorary contracts, to ensure that they can exercise holding powers outside of their substantive Trust. While I note that this arrangement was not in place in Rachel's case, NHS England has engaged with NHS Sussex Integrated Care Board (ICB) on this matter, who have advised that the following actions are being undertaken:

- Pathway review at place and system level is being undertaken.
- SPFT are in the planning stages of putting together a business case for direct employment of Mental Health Staff by the acute providers.
- Sussex ICB are investigating the issues raised your Report with SPFT and considering any improvements that can be made to the safety of patients who are brought to A&E in the acute sector and who need to be detained under s5(2) and s5(4) of the MHA in response to HM Coroner's concerns.
- The ICB has also approached the Mental Health Team Commissioners for their input.

NHS England will also be raising this case with the Department for Health and Social Education who have responsibility for Mental Health Act legislation, for their consideration of the issues raised.

I would also like to provide further assurances on national NHS England 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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Medical Director for Professional Leadership and Clinical Effectiveness
NHS England