NHS England

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8 January 2024

Dear Coroner,

**Re: Regulation 28 Report to Prevent Future Deaths – Christopher Richard Allum who died on 15 May 2022.**

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 10 November 2023 concerning the death of Christopher Richard Allum on 15 May 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Christopher's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Christopher's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused to Christopher's family or friends. 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.

In preparing this response, your Report was reviewed by specialist colleagues from the national Mental Health Team at NHS England, the Getting It Right First Time Programme for crisis and acute mental health and Specialised Commissioning for Mental Health, all of whom have provided input.

Your Report raised concerns over gaps in obtaining information about and recording previous methods of self-harm and suicide at initial referral and admission stage and in seeking and recording relevant information from an individual's family.

The Langford Centre is operated by Bramley Healthcare, an independent Mental Health Care Provider providing services within the South of England. I note that you have also addressed your Report to the Centre, and they would be the appropriate organisation to respond to the above concerns. NHS England will carefully review and consider their response to you.

Christopher was sadly at high risk of suicide and self-harm at the time of his admission to the Langdale Centre, and I note that this was included in the referral notes received by the Centre. While the referral paperwork unfortunately did not refer to the previous ligature attempt made by Christopher, Clinical Leads at NHS England have advised that it should still have been part of any risk management plan given Christopher's risk

of suicide. It is also not clear to NHS England from your Report why Christopher's care notes were not accessed by staff at the Centre until after his death.

While we await further correspondence, NHS England does understand from the Langford Centre that they have taken actions to address the gaps identified by the coroner which has included amendment to their Acute Referral Form. The new referral form includes boxes to record details of previous suicide and self-harm attempts and methods used. It also includes a box for relative/care views and information as well as a requirement to provide a reason if they have not been contacted to discuss the referral.

Christopher's case does highlight the importance of effective information sharing to support providing the best care possible where individuals are transferred between different care settings. That is why joined up partnership working is one of the four key principles underpinning NHS England's guidance on Acute inpatient mental health care for adults and older adults that was published in July 2023. This document provides specific advice on good practice on information sharing as well as guidance on the holistic assessment that should take place when someone enters a new facility, including identifying any safeguarding or risk issues, including risk to self and others. This includes guidance on the key actions that should take place within 72 hours of admission which include:

- Person's electronic patient record (EPR) reviewed (including identifying any recorded advance choices and reasonable adjustments required), checking back key information from the person's EPR with them and their chosen carer/s and noting any changes/updates.

- Holistic assessment completed and uploaded to the person's EPR.

- Purpose of admission statement and estimated discharge date (EDD) agreed with the person and their chosen carer/s and uploaded to the person's EPR.

- Interventions and treatment for physical and mental health conditions commenced/maintained, and a physical health check completed.

- Formulation review completed and care planning begun.

- Discharge planning begun – identifying what needs to happen for discharge to occur.

Where an independent provider is not able to access an EPR for any reason, rapid access to the information through other avenues should be part of local protocols.

While I note that this guidance was published after Christopher's death, I hope that it provides some assurance to the coroner and Christopher's family around the current guidance and processes in place to support providers in preventing the issues in Christopher's care from occurring in the future.

In 2022, NHS England also established its Mental Health, Learning Disability and Autism Inpatient Transformation Programme to support cultural change and

implement a new model of care for the future across all NHS funded mental health, learning disability and autism inpatient settings. As part of the Programme, all mental health inpatient independent sector providers will receive support to move away the use of risk assessment tools to co-produced safety planning in line with guidelines from the National Institute for Health & Care Excellence (NICE), and the Government's Suicide Prevention Strategy, from 2024 onwards. The Programme also includes a focus on increasing the role of family voice.

Your Report also raised concerns around the difficulties faced by the private sector in accessing NHS patient notes.

NHS England is working to enhance the sharing of patient information to and from Voluntary, Charity and Social Enterprise (VCSE) and other independent sector providers who are commissioned by NHS organisations.

VCSE and other independent sector providers, commissioned by the NHS are increasingly being connected to Local Shared Care Records (SCR). Integrated Care Boards (ICBs) are responsible for determining which organisations should be connected to their local SCRs, and to support them to connect. Over the next two years, there is a requirement for ICBs to connect all Local Authorities with a social care responsibility and a 'priority' list of community care providers, which includes numerous independent sector providers commissioned by NHS organisations, to their local SCRs.

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,

[redacted]
National Medical Director