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28 March 2024

Dear Coroner

Re: Regulation 28 Report to Prevent Future Deaths – Abdullah Popalzai who died on 29 November 2019.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 5 February 2024 concerning the death of Abdullah Popalzai on 29th November 2019. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Abdullah's family and loved ones. NHS England is keen to assure the family, and the coroner, that the concerns raised about Abdullah's care have been listened to and reflected upon.

Your Report raised the concern that prisoners who are acutely psychotic and refusing treatment that requires transfer to hospital under the Mental Health Act, are being left untreated and at risk of further deterioration due to a shortage of suitable psychiatric hospital bed spaces becoming available in a timely way.

I note from your Report there were two incidents which included:

a) assessment for a bed whilst in court, a bed couldn't be found in time and Mr Popalzai was therefore remanded in custody; and
b) access to a hospital bed following being assessed on 09 October 2019 and 18 October 2019 as suitable for admission under the Mental Health Act.

NHS England is committed to ensuring access to timely, responsive, and least restrictive mental health care and is already working to address issues in this area by focusing on increasing access to hospital beds pre-sentence, rather than prison being used as a place of safety.

Access to mental health beds for people in custody should be considered as part of wider plans for how systems meet the mental health needs of the population. The number of mental health beds required to support a local population is dependent on both local mental health need, and the effectiveness of the whole local mental health system in providing timely access to care, and supporting people to stay well in the community, therefore reducing the likelihood of an admission being necessary.

In some local areas there is a need for more beds, which is being addressed in part through investment in new units. This should be considered as part of a whole system transformation approach.

This is supported by the NHS Long Term Plan (LTP), which is seeing an additional £2.3bn funding invested in mental health services from 2019/20 – 2023/24, around £1.3bn of which is for adult community, crisis, and acute mental health services to help people get quicker access to the care they need and prevent avoidable deterioration and hospital admission.

To improve access to local beds and flow through acute pathways, an additional £700m was made available during the winter period in 2022/23 and a further £1.6bn via the 'better care' fund from 2023-25. This funding can be used to support mental health inpatient services as well as the wider system, which should help to reduce pressures on local inpatient services so those who need to access beds can do so quickly and locally.

I would like to assure you that following the sad death of Mr Popalzai, lessons have, and will continue to be learnt. NHS England's Health and Justice team is undertaking significant work around early identification, treatment and support of people who require mental health support, along with increasing access to hospital beds whilst people are held on remand and focusing on speeding up access to a bed for those held in custody.

His Majesty's Inspectorate of Prisons (HMIP) recently published the report The long wait: A thematic review of delays in the transfer of mentally unwell prisoners which outlines similar issues. NHS England is also addressing the areas of concern and lessons learnt within this report.

This ongoing work will ensure people have access to the right care and treatment, including access to the right hospital bed for people within the Criminal Justice System (CJS).

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