

**Fiona Wilcox**

HM Senior Coroner Inner West London  
Westminster Coroner's Court  
65 Horseferry Road  
London  
SW1P 2ED

**National Medical Director**

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

26 April 2024

Dear Coroner,

**Re: Regulation 28 Report to Prevent Future Deaths – Roberto Bottello who died on 16<sup>th</sup> September 2020.**

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 16<sup>th</sup> February 2024 concerning the death of Roberto Bottello on 16<sup>th</sup> September 2020. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Roberto's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Roberto'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 Roberto'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.

We note that you have also sent your Report to Central and North West London NHS Foundation Trust ("the Trust") and The Commissioner of Police of the Metropolis for whom the majority of the concerns relate to. We have been sighted on the Trust's response to you and note that it details a number of changes to the provision of care and services across the Trust. This response addresses those concerns which come under the remit of NHS England national policy or programmes, referenced below.

**Concern number 6 - Psychiatric liaison nurses and psychiatric liaison doctors should have regard to diagnoses made by other doctors**

All healthcare professionals should have regard to a patient's medical history and diagnoses. There are several patient record sharing options available to clinicians to access an individual's medical history. These include [Shared Care Records](#), Summary Care Records and the [National Care Records Service](#).

**Concern numbers' 7 & 10 - That most Section 136 usage is out of hours when there is less resource to respond to psychiatric services and that there are continued shortages in psychiatric care provision**

In 2016, NHS England published its [7-Day Hospital Services \(7DS\) Programme](#) which introduced clinical standards regarding the provision of a “truly seven-day NHS” and requiring acute Trusts to provide board assurance compliance. The Programme focuses on the provision of acute medical care in such a way that there is no difference in quality for patients, whichever day they attend at hospital. The NHS continues to encourage local health systems to develop effective workforce planning to ensure that they have the sufficient qualified staff working across their Trusts and wider system that are required for their population care needs. The [NHS People Promise](#) helps NHS providers to consider ways to recruit and retain staff.

Workforce and staffing levels continue to be a challenge across the NHS, and we know that this can present issues to Trusts. In June 2023, NHS England published the [NHS Long Term Workforce Plan](#), setting out how it will train, retain and reform its workforce across the next fifteen years to ensure that we are improving access, providing safe and timely urgent and emergency care and continuing to reduce elective care backlogs. The Plan is underpinned by the biggest recruitment drive in NHS history and includes focus on growing the psychiatric care workforce.

Psychological professionals, comprising psychologists, psychological therapists, and psychological practitioners, are making a rapidly growing contribution to the NHS across mental health and physical health services. Education and training places for clinical psychology and child and adolescent psychotherapy are estimated to need to grow by at least 20–33%, reaching 1,258–1,397 by 2033/34. Our ambition is to grow these training places by 26% by 2031/32. To support working towards this ambition, training places for clinical psychology and child and adolescent psychotherapy will be more than 1,000 each year up to 2028/29.

In addition to education and training for clinical psychologists and child and adolescent psychotherapists, over the next three years NHS England has committed funding of over £600 million to grow the wider psychological professions workforce through training approximately 15,000 more individuals to undertake psychological therapist and psychological practitioner roles. Training places for mental health nursing will also increase by 38%. The Long-Term Workforce Plan makes a commitment to keep the mental health workforce under review.

### **Concern number 9: The use of film over glass should be more widespread in the NHS England estate**

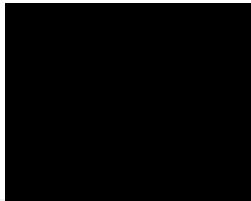
Estate management is the responsibility of each individual NHS Trust. I note that a Serious Incident Investigation was undertaken by the Trust in this matter and recommendations were made to consider reconfiguring the space to provide a more appropriate place of safety for mental health patients. We are advised that the Trust will be reviewing their windows to ascertain whether reinforced toughened glass can be fitted.

Your Report has been shared with my colleagues within our national Mental Health and Specialised Commissioning Teams who will consider whether any further action needs to be taken regarding your concerns. Colleagues from each of the seven regions will also be asked to share the learnings from Roberto’s care within their health and care systems.

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 name]

National Medical Director