Darren Stewart OBE
Suffolk Coroner's Court and Offices
Beacon House
Whitehouse Road
Ipswich
IP1 5PB

[redacted]

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

[redacted]

22nd May 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Ellen Ocean Woolnough who died on 28 July 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 28 March 2024 concerning the death of Ellen Ocean Woolnough on 28 July 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Ellen's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Ellen's care have been listened to and reflected upon.

I note that your Report has also been addressed to Norfolk and Suffolk NHS Foundation Trust who are the appropriate organisation to answer the majority of the concerns raised in your Report. NHS England has engaged with the Trust on the issues raised in your Report about Ellen's care and and have been sighted on the action plan and statement submitted to you at inquest. We note from the Trust that their actions include:

- A Quality Improvement Programme led by their Chief Nurse which will focus on improving clinical standards and implementing a positive culture change.
- Re-evaluation of the Trust-wide training standard and model for risk assessment/ Skills Training on Risk Management (STORM).
- The implementation of a new Trust-wide Crisis Rehabilitation Home Treatment Team (CRHTT) Standard Operating Procedure (SOP) and handover document in May 2024.
- Changes made to the Patient Safety Screening Form which include a prompt to consider whether calls are available for retrieval.

I would refer you to the Trust's response to your Report for further details and actions taken. NHS England have also been asked to be sighted on their response.

Regarding concern iv) and the changes to the way that the Trust is now investigating patient safety incidents and the implementation of the Patient Safety Incident Response Framework (PSIRF), my colleagues from the national Patient Safety Team at NHS England reviewed your Report and have provided input.

The PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The PSIRF has replaced the Serious Incident Framework (2015) and represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement.

NHS England would refer the coroner to the Trust for further details about their implementation of PSIRF.

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]

[redacted]
National Medical Director