Mr Xavier Mooyaart
HM Assistant Coroner
Inner South London Coroner Area
Southwark Coroner's Court
1 Tennis Street
London
SE1 1YD

[redacted]

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

[redacted]

25 July 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Mr Jada Monoja who died on 17 November 2020

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 17 May 2024 concerning the death of Jada Monoja on 17 November 2020. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Jada's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Jada's care have been listened to and reflected upon.

Your Report raised concerns over the Risk Assessment Tool used in Jada's case and that it was not used in line with Oxleas NHS Foundation Trust (Oxleas) policy.

One of the key actions set out in the Government's Suicide Prevention Strategy (published on 11 September 2023) was that NHS England would identify opportunities to improve the quality and culture of risk management and safety planning within mental health services. The position regarding risk assessments was included in the NHS England guidance to improve the culture of care for mental health inpatient services in April 2024: Culture of care standards for mental health inpatient services.

The Suicide Prevention Strategy also stated that NHS England would scope and start delivery of training and quality improvement programmes. It is important that culture and practice across mental health services reflects an individualised, person-centred approach to safety-planning and risk management, and that access to appropriate support is not closed off as a result of assessments of risk.

Following engagement from my London regional colleagues, Oxleas have advised the South East London Integrated Care Board that that they designed a clinical risk training workshop, for clinicians who work with people with mental health illness, on risk assessment and formulation. The training supports teams to apply a personalised approach to risk assessment and risk formulation based on data and recommendations from The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). The training addresses the emerging concerns about over-reliance on risk assessment tools and risk rating in predicting suicide risk, offering important clinical messages for daily practice. Oxleas are also an active participant in

the Royal College of Psychiatrists' Culture of Care Programme, which is a programme aimed at improving the culture of inpatient mental health, learning disability and autism wards so that they are safe, therapeutic and equitable places in which to be cared for. I note that you have also addressed your Report to Oxleas, who may be able to provide you with further information around your concerns.

I would also like to provide further assurances on the 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 events, such as the sad death of Jada, are shared across the NHS at both a national and regional level and helps us to 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