Mr James Bennett
Area Coroner for Birmingham and Solihull
The Birmingham
and Solihull Coroner's Court
Steelhouse Lane
Birmingham
B4 6BJ

[redacted]

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

[redacted]

12 July 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Tcherno Bari who died on 26 September 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 3 June 2024 concerning the death of Tcherno Bari on 26 September 2023, sent to the Chair of NHS England. I am responding on behalf of the organisation in my capacity as National Medical Director but would like to assure you that the Chair has also been sighted on this response and has reviewed your Report. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Tcherno's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Tcherno's care have been listened to and reflected upon.

Your Report raises concerns over gaps in knowledge and the coordination and application of the local policies in place, and in use by Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) and West Midlands Police (WMP), for high-risk mental health patients that go missing, requiring effective and meaningful multi-agency coordination. I note that you have directed your Report to NHS England as a party to the National Partnership Agreement: Right Care, Right Person (RCRP) and our response to you focuses only on the areas of concern that come under our remit.

The National Partnership Agreement: Right Care, Right Person (RCRP), which was published in July 2023 and which NHS England is a signatory to, sets out a collective national commitment to work to end the inappropriate involvement of police in responding to incidents involving people with mental health needs. The RCRP outlines key principles for implementation, including that a strong multi-agency governance structure is needed to plan and develop the approach to delivery locally, so that patient safety is not compromised and people are not left without the support they need. The RCRP also states that local partners should work together to monitor and review progress with implementation and set up local escalation processes to support multi-agency partners to resolve challenges with rollout.

To support implementation, NHS England has shared information with health systems about setting up multi-agency governance and delivery structures to oversee delivery, manage risks and escalations and enable open communication between local

partners, including to resolve any challenges. Information has also been shared on escalation protocols, including the need for local partners to set up real-time escalation processes (in response to a situation that is currently live) and retrospective escalation processes (to review situations that have occurred, learn lessons and agree changes going forward). This information will be included in guidance that NHS England will issue to health systems shortly.

NHS England takes all reports of actions that have not followed the principles of RCRP seriously. A national oversight group has been set up, involving members from all organisations that signed the RCRP, as well as representatives from wider health, children and adult's social care, police and voluntary, community, faith and social enterprise (VCFSE) sector organisations. The purpose of this group is to review any concerns and issues with RCRP that have been escalated nationally, to identify any action required by national partners in relation to concerns and issues raised. This oversight group feeds into a regular ministerial working group set-up to oversee RCRP roll-out.

It is appropriate that BSMHFT and WMP respond to many of the concerns raised in your Report. My Midlands colleagues have shared your Report with the Chief Medical Officer for Birmingham and Solihull Integrated Care Board, as the commissioner of services from BSMHFT, to ensure that they seek assurance from both BSMHFT and WMP that the concerns in your Report have been addressed.

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 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