Ms Sonia Hayes
Area Coroner for Essex
Essex and Thurrock Coroner's Service
Essex County Council
Seax House
Victoria Road South
Chelmsford
CM1 1QH

[redacted]

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

[redacted]

11 September 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Aaron James Deeley who died on 14 January 2022

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 19 June 2024 concerning the death of Aaron James Deeley on 14 January 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Aaron's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Aaron'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 Aaron'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.

Your Response raised the concern that that there is a lacuna for patients awaiting Mental Health Act assessment and requiring simultaneous physical healthcare when a significant risk has been identified, such that a patient may require detention for their own safety. My colleagues in the National Adult Mental Health Team at NHS England have reviewed your Report and concerns and they have input into this response.

National guidance on urgent and emergency Liaison Mental Health Services for adults states that liaison mental health teams should "be proactively involved in the person's treatment and be ready to provide mental health input as soon as the person is able to be seen. This should not be just a request to be notified when the person is declared medically cleared, which can often lead to undue delays in the pathway." The guidance is also clear that within four hours of arriving in an Emergency Department ('ED') or being referred from a ward, it is recommended that the person should have received a full biopsychosocial assessment and have an urgent and emergency mental health care plan in place.

Section 5(2) of the Mental Health Act 1983 gives relevant clinicians the ability to detain a patient in hospital for up to 72 hours, during which time they should receive an assessment that decides if further detention under the Mental Health Act is necessary.

The fact that someone is subject to a section 5(2) detention and is in receipt of treatment for a physical health condition, which means that they need to remain under the care of the acute trust, should not prevent the liaison mental health team from providing ongoing support for that individual and advice to wider ED staff on approach to care and treatment.

Your Report also raised concerns over the policy at Mid & South Essex NHS Foundation Trust (MSEFT) for observation of patients awaiting Mental Health Act assessments, and that there was no joint protocol between MSEFT and Essex Partnership University NHS Foundation Trust (EPUT) addressing the issue of referrals for Mental Health Act assessments. We note that you have also addressed your Report to these Trusts, and we have been sighted on their responses. We note the actions that have been taken, including the organisation of a joint Working Group between MSEFT, EPUT and Mid and South Essex Integrated Care Board to address the concerns raised about joint protocol and ways of working.

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 Aaron, 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,

National Medical Director