Mr Andrew Harris
Assistant Coroner
South London Coroner's Service
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Davis House
Robert Street
Croydon
CR0 1QQ

[redacted]

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

[redacted]

26/09/2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Emily Rose Collishaw who died on Wednesday 6 September 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 27 June 2024 concerning the death of Emily Rose Collishaw on 6 September 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Emily's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Emily's care have been listened to and reflected upon.

Your Report raised the concern that the organisations working with Emily took time to agree their different roles, that the level of support provided was insufficient and that the referral for residential care should have been made earlier. You also raised that the delay in accessing residential care has progressively been getting longer over the past 10 years, which poses risks such as sudden death to patients.

NHS England has been engaging with South East London Integrated Care Board (SEL ICB), who we note you have also sent your Report to. We are advised by SEL ICB that Mental Health colleagues have reviewed Emily's care and consider that there is evidence of coordination between the Home Treatment Team and the Pier Road Project (PRP) interface, to include joint visits and information sharing, as well as consultation with the family. I would refer you to SEL ICB's full response to your Report for further information.

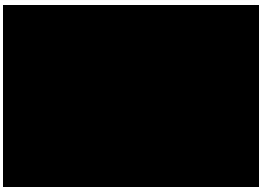
The PRP is commissioned locally by the Local Authority, London Borough of Bexley, as is usual for drug and alcohol rehabilitation services for which responsibility sits with local government, overseen by the Department of Health and Social Care (DHSC). I note that you have also addressed your Report to the DHSC, as well as the Department of Levelling Up, Housing and Communities, and it would be more appropriate for the government to comment on your concerns about wait times for residential rehabilitation placements.

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 Emily, 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