NHS England

Mr Christopher Murray
HM Assistant Coroner
Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

National Director of Patient Safety
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted] [redacted]

25 November 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Michael Sean Heath who died on 25 August 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 2 October 2024 concerning the death of Michael Sean Heath on 25 August 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Michael's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Michael's care have been listened to and reflected upon.

We note that your Report has also been addressed to individuals including the Home Secretary and the Minister of Policing, along with organisations including the Greater Manchester Mental Health NHS Foundation Trust, North West Ambulance Service, Greater Manchester Police and Trafford Council. It is appropriate that these individuals and organisations address some of the matters of concern, namely around those issues relating to policing, advocacy and communication and access to information between the local agencies and staff involved in Michael's care. NHS England will review and consider carefully the other responses in due course.

Regarding your concern over the apparent lack of connectivity between mental health services abroad and the UK, whilst it would be NHS England's hope that, in the patient's best interests, when a patient is medically repatriated there will be appropriate sharing of clinical information between the discharging and receiving healthcare providers, this cannot be mandated for overseas healthcare providers.

Further, where a patient makes their own arrangements to return to the UK independent of an overseas healthcare provider, there can be no expectation that a provider would be aware of the patient's travel arrangements unless the patient themselves notifies the relevant provider of their return. In this case, it is our understanding that Michael made his own travel arrangements independent of an overseas healthcare provider, and did not notify a provider in England of his return.

It is also not clear to NHS England from your Report whether the Mental Health Act admission referred to was in Gibraltar, or in England, which makes it difficult for NHS England to comment further on Michael's care. We would be happy to review further details to the extent that this falls within NHS England's remit, if that is helpful to the Coroner.

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 Michael, 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 Director of Patient Safety