Simon Milburn
HM Area Coroner
Cambridgeshire & Peterborough Coroner Service
Lawrence Court
Princes Street
Huntingdon
PE29 3PA

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

[redacted]

18 December 2024

[redacted]

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Declan Gordon Gerard Morrison who died on 2 April 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 23 October 2024 concerning the death of Declan Gordon Gerard Morrison on 2 April 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Declan's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Declan's care have been listened to and reflected upon.

Your Report raises concerns regarding the availability and provision of residential care and mental health placements for people with complex needs in the community and within the NHS. My response has been informed by the Learning Disability and Autism Programme team at NHS England. We very much recognise the importance of there being the right mental health support and care for people in their local area, including for people like Declan who may have multiple, complex and/or high levels of need.

In 2024/25, NHS England made available £124 million for local areas to invest in community services to help prevent the need for admission to mental health hospitals for people with a learning disability and autistic people. In line with the commitments set out in the NHS Long-Term Plan published in 2019, we would expect local areas to have community alternatives to hospital in place, including crisis and intensive support for people at greatest risk of admission.

In line with NHS England's Care (Education) and Treatment Review and Dynamic Support Register policy (NHS England » Dynamic support register and Care (Education) and Treatment Review policy and guide), we would expect each local system to have an awareness of people with a learning disability and autistic people in the local area who are at risk of a mental health hospital admission, so that agencies can plan and put in place support that may help to keep the person living well in the community.

NHS England has worked with the Local Government Association and the Association of Directors of Adult Social Service to develop a set of guiding principles, published in 2023 (NHS England » Joint guiding principles for integrated care systems – learning disability and autism) for integrated care systems, setting out how partners in local

systems can work together to improve the lives and outcomes of people with a learning disability and autistic people, of all ages. It includes guidance on commissioning the right community services to meet the needs of people with a learning disability and autistic people.

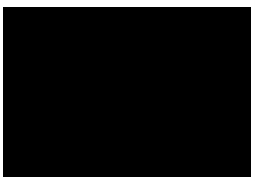
NHS England has also commissioned six new Neighbourhood Mental Health Centres, offering 24/7 community support for individuals with serious mental illness. These centres integrate crisis intervention, community support, and open access beds to facilitate extra support, tailored to local needs. This includes support for people who have a learning disability and who are autistic. These Mental Health Centres in local neighbourhoods enable individuals to visit without a referral, to receive help from a range of professionals including psychiatrists, social workers, and peer support workers, and support such as psychological therapies, medication support, and assistance with related issues such as housing or employment. Each centre, led by an NHS provider, will work in partnership with people with lived experience, as well as voluntary, charity, faith and social enterprise organisations. The two-year pilot programme is across six neighbourhoods, all of which have their own marginalised populations that do not tend to have access mental health services. The pilot sites received their first funding allocation in July 2025, and this will continue into 2025/26.

We note that your Report is also addressed to Cambridgeshire and Peterborough Integrated Care Board (ICB), the responsible commissioner for Declan's care, and we are aware they have responded to the Coroner separately to outline the learning they have undertaken in response to this case and the next steps they will be taking to enhance service development for complex patients. We are aware that this includes work to better support patients under a Mental Health Act and an outline of the ICB's work to transform services for people with mental health, learning disabilities and autism, including ensuring that there is no inappropriate detention of individuals with learning disabilities and/or who are autistic.

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 Declan, 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,



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National Medical Director