[redacted]
Parliamentary Under-Secretary of State for
Patient Safety, Women's Health and Mental Health

39 Victoria Street
London SW1H 0EU

Department of Health & Social Care

Our Ref: [redacted]

Melanie Sarah Lee
Assistant Coroner
Inner North London St
Pancras Coroner's Court
Camley Street
London
N1C 4PP

23 December 2024

Dear Ms Lee

Thank you for your Regulation 28 report to prevent future deaths dated 4 November 2024 about the death of Jagjeet Singh. I am replying as the Minister with responsibility for mental health and patient safety.

Firstly, I would like to say how saddened I was to read of the circumstances of Jagjeet's death and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

I understand your concerns about a bed on the mental health ward not being available for Mr Singh when he was discharged from the medical wards. I note that you have also addressed these matters of concern to the Chief Executive of NHS England. I look forward to seeing her response and working with NHS England where appropriate, to avoid a repetition of the tragic events of this case.

I recognise the impact that a suitable bed not being available can have on a patient's care, as exemplified in Jagjeet's case.

I am sure you will appreciate that the number of mental health inpatient beds required to support a local population is dependent on both local mental health need and the effectiveness of the whole local mental health system in providing timely access to care and supporting people to stay well in the community, therefore reducing the likelihood of an inpatient admission being necessary.

I expect individual trusts and local health systems to effectively assess and manage bed capacity, the 'flow' of patients being discharged or moving to another setting and the availability of specialist personality disorder rehabilitation units. I recognise that mental health services have been under significant strain in recent years due to the rise in demand.

Over the past few years, the NHS has been developing the community mental health framework with the aim of improving community support for people with severe mental illness, thus avoiding the need for an inpatient admission where possible and freeing up more beds.

NHS England's 2024/25 priorities and operational planning guidance reinforces this focus on improving patient flow as a key priority – with local health systems directed to reduce the average length of stay in adult acute mental health wards to deliver more timely access to local beds. And in areas where there is a clear need for more beds, this has been addressed in part through investment in new units.

It is also important that when people are discharged, this happens in a way that considers their needs on discharge and any risks to their safety. To help support safe and timely discharge decisions, the Department published statutory guidance on *Discharge from mental health inpatient settings* in January 2024 and which is available at: Discharge from mental health inpatient settings - GOV.UK (www.gov.uk). This sets out how health and care systems should work together to support safe discharge from all mental health and learning disability and autism inpatient settings for children, young people and adults.

As part of our mission to build an NHS fit for the future, we will make sure more mental health care is delivered in the community, close to people's homes, through new models of care and support, so that fewer people need to go into hospital.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,

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