Penelope Schofield
HM Senior Coroner,
West Sussex, Brighton & Hove
Record Office,
Orchard Street
Chichester
PO19 1DD

[redacted]

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

[redacted]

24 February 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Matthew Zak Sheldrick who died on 4 November 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 16 December 2024 concerning the death of Matthew Zak Sheldrick (known as Matty) on 4 November 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Matty's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Matty's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to respond to your Report, and I apologise for any anguish this delay may have caused to Matthew'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 Report raises concerns about the service provision and availability of services for patients suffering with their mental health, and the appropriateness of the Emergency Department as an environment for people who are autistic and/or neurodiverse to be held as they await a mental health bed. My response to the Coroner addresses the issues raised that sit within NHS England's national policy and programme remit.

Shortage of mental health inpatient beds and unacceptable waiting times in Accident and Emergency (A&E) for patients suffering with their mental health and for onward referrals.

Increased waiting times for inpatient beds have been contributed to by longer stays in hospital and the length of time required to discharge patients who are clinically ready to leave hospital. This, alongside a 48% increase in referrals to community crisis services since the pandemic, and despite the NHS Long Term Plan's (LTP) expansion and transformation of these services, has affected how quickly patients can access local beds.

The number of mental health beds required to support a local population is dependent on local mental health needs and the effectiveness of the whole local mental health system in providing timely access and care and supporting people to stay well in the community, therefore reducing the likelihood of a hospital admission being necessary. In some local areas there is a need for more beds; this is being addressed in part through investment in new units, however, this should be considered as part of a whole system transformation approach.

The NHS LTP saw an additional £2.3 billion of funding invested in mental health services from 2019/20 to 2023/24, around £1.3 billion of which was for adult community, crisis and acute mental health services to allow people to get faster access to the care they need and prevent deterioration and hospital admission where it is avoidable. The NHS 111 mental health call option has also been established around the country to support reductions in A&E attendance and Mental Health Response Vehicles have also been established to see and treat patients away from an A&E setting. New integrated operational pressures escalation levels (OPEL) scoring systems have also been established for mental health, enabling greater transparency and escalation of risks across mental health pathways.

NHS England's 2024/25 priorities and operational planning guidance continues this focus on improving patient flow as a key priority – with systems directed to reduce the average length of stay in adult acute mental health wards in order to deliver more timely access to local beds. This is being supplemented by a further £42 million recurrent investment from 2024/25, for all Integrated Care Boards (ICBs) in the country to recommission inpatient care in line with local models that provide the best evidence of therapeutic support.

Existing crisis services, such as liaison psychiatry services, local crisis resolution and home treatment (CRHT) teams are also in place to help support people suffering mental health crisis, but who do not meet the criteria for admission. Additionally, the Urgent and Emergency Care Recovery Plan has also set out that the NHS is investing an additional £150 million capital funding for new projects to support urgent mental health care and crisis response. This will also help to support people to be provided with the care and support they need closer to home and reduce the number of admissions to hospital.

A&E is an unsuitable environment for autistic and/or neurodiverse people to be held when waiting for a mental health bed. There is a lack of inpatient bed provision for informal patients, in particular for those who are autistic and those who are transgender, requiring a mixed ward.

Patients attending A&E suffering with a mental health crisis remain there until a suitable mental health bed can be found. Since the introduction of the Mental Health Crisis Care Concordat, investment was secured to provide 24-hour access to Liaison Psychiatry Services in 70% of hospitals in England by the end of 2023/24. On arrival, patients should receive a mental health triage assessment to determine the level of observation they require and where they should be placed within the A&E department.

NHS England's guidance (NHS England » Meeting the needs of autistic adults in mental health services), which is aimed at ICBs, health organisations and wider system partners, was published in December 2023. The guidance includes information in relation to accommodating people's sensory reactivity, which would also apply to acute healthcare settings, including:

- Helping people to self-manage their needs by providing information in advance about the layout and sensory environment of clinical spaces. This could be in the form of a video made available on the clinic website of the route from the car park to the treatment room.

- Offering waiting environments that are considerate to sensory reactivity. The NHS England sensory resource pack may be relevant. This includes the Green Light Toolkit which was designed to support service improvement.

- Providing resources to help autistic people cope with the sensory environment, such as sensory care bags in waiting rooms or on hospital wards.

- Assessing autistic adults' sensory needs and recording identified adjustments in their health/communication passport.

- If a waiting room environment is distressing for an autistic adult, the service should offer a different waiting area where autistic adults have more control over the sound, light, temperature or smells, or it should arrange with the person where they would rather wait.

Reasonable adjustments as described in the Equality Act 2010 also require public sector organisations to make changes in their approach or provision to ensure that services are accessible to all.

Mixed 'sex' ward accommodation was eradicated in the NHS in 2010 and, in Matty's case, the Royal Sussex County Hospital would have deferred to their internal policy / guidance to admit Matty. NHS England cannot comment on the availability of inpatient accommodation at a local provider level.

Local information

NHS England's South East regional colleagues have also engaged with NHS Sussex ICB, the responsible commissioner for the services described, on the concerns raised. We are advised that they have identified actions which include the provision of leaflets to patients and carers explaining delays in access to mental health beds, with information and signposting to support lines and apps. There are also now arrangements in place to support escalation and clinical discussion of patient flow and referral reviews. The ICB have requested an update from the Trust on their action plan, following Matty's death.

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 Matty, 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