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Area Coroner
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National Medical Director
NHS England
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27 February 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Oliver James Winson who died on 10 June 2024

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 20 December 2024 concerning the death of Oliver James Winson on 10 June 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Oliver's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Oliver's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused Oliver's family or friends. I realise that responses to Coroners' Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones, and I appreciate this will have been an incredibly difficult time for them.

Your Report notes that, despite local and national efforts, the scale of demand for adult ADHD services is a system wide issue across the country. You raised the concern that patients who have been identified specifically of being at risk as a result of undiagnosed and/or untreated ADHD remain on significantly lengthy waiting lists, during which time they are not receiving treatment, their condition is not monitored and there is a risk that their condition may deteriorate or lead to risk or harmful behaviour and death.

NHS England are aware that there are extensive waits for ADHD services nationally, including for assessment of ADHD. The number of people requesting assessments for attention deficit hyperactivity disorder (ADHD) has grown exponentially in recent years, with the number of adults waiting for a first appointment doubling each year since 2018[1].

We recognise that those awaiting support for ADHD might have other conditions which may be impacted by their ADHD symptoms, and that those with ADHD are at higher risk of a range of adverse outcomes, including substance abuse disorder, suicide and accidental death compared with those without ADHD.

[1] Darzi Report

ADHD services are a complex landscape. They are commissioned locally by Integrated Care Boards (ICBs) with significant national variation existing in pathways and provision, including independent sector providers operating under the Right to Choose framework.

Considering the challenges being reported about ADHD services, NHS England undertook a rapid review in December 2023. This identified several key areas of work in relation to ADHD which are now underway, including improving available data, developing resources to support commissioners in improving the quality and consistency of ADHD services nationally, and facilitating the sharing of information, innovation and good practice. NHS England has also convened the independent ADHD Taskforce, which works cross-sector to understand more about the issues impacting those with ADHD and their families, and how service provision can be better joined up to meet people's needs, including access to early support. It is increasingly recognised that ADHD is not solely a health concern, and that a cross-sector approach is needed to effect change.

NHS England is committed to working with system partners, including commissioners and providers of ADHD support, to improve health-related experience and outcomes for those with ADHD, including exploring opportunities to:

- Revise information on ADHD available to patients, families and carers via the nhs.uk website, the NHS's primary patient information resource (led by NHS England, anticipated February 2025).
- Standardise pathways to improve consistency and transparency for those with ADHD, their families and carers.
- Expand the scope of existing care pathways to offer greater support for those with ADHD, their families and carers. This may include pre-diagnostic or 'waiting well' support, which focuses on what can be done to support the individual ahead of assessment and/or diagnosis.
- Move to a needs-based approach, which focuses on understanding the specific challenges an individual is facing, ensuring they receive the most appropriate support for those challenges. This might include support outside of health services, such as at school or in the workplace.

Your Report also referred to there being a shortage of medication for those patients who have been diagnosed with ADHD. NHS England works closely with the Department of Health and Social Care (DHSC), who are responsible for medication supplies in England. NHS England has developed specific guidance for systems, shared via the Specialist Pharmacy Service, to support the system response to the medication shortages. At this time, the availability of most medicines used to treat ADHD has been restored, though there remains some disruption to supplies of methylphenidate prolonged-release capsules and tablets[2].

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

[2] Prescribing available medicines to treat ADHD – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

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 Oliver, 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