NHS England

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[redacted]

National Medical Director
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19 March 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Joseph Benjamin Forbes Black who died on 9 August 2023

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 2 January 2025 concerning the death of Joseph Benjamin Forbes Black on 9 August 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Joseph's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Joseph'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 Joseph'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 raised the concern that naloxone kits are not more widely available nationally, and that a significant proportion of illicit drug users do not engage with substance misuse services, when it is these services that could supply naloxone.

The responsibility for commissioning drug dependency services rests with local authorities. I note that you have also addressed your Report to the Secretary of State for Health and Social Care, and it is their Department (DHSC) that is the more appropriate organisation to response to your concerns.

Previous legislation meant that only drug and alcohol treatment services were able to supply naloxone for the indication described in this case. However, last year the DHSC consulted on widening access to naloxone: Expanding access to naloxone - GOV.UK.

Following this, community pharmacies can now, in practice, provide take-home naloxone without a prescription to reverse potential opiate overdoses to those who need it. However, the scope of what local authorities choose to commission through community pharmacies also varies and there is currently no requirement for them to supply naloxone and this would be a decision for local government.

My regional Patient Safety colleagues for London have also engaged with Islington Better Lives, part of the North London NHS Foundation Trust, and commissioned by the London Borough of Islington council.

Naloxone provision is a fundamental part of the service delivery and they have advised that they ensure maximum reach and distribution in the following ways:

- All opiate using clients are offered Naloxone as soon as they enter treatment and are given training on how it is administered.
- Clients are routinely given 2 x kits (either injectable or nasal spray or both) with a warning that they may require more naloxone if they or others overdose on heroin which has been mixed with Nitazines (Fentanyl etc.)
- All other clients are also offered Naloxone in case they encounter individuals in overdose.
- High risk groups are considered (e.g., hostel-dwelling and those in contact with criminal justice systems where release from prison increases risk of overdose). Supply of Naloxone is issued to an array of clients including in probation and court environments, as well as being made available at hostel receptions.
- The service actively encourages clients to access treatment by making this as easy as possible: being in treatment reduces some of the risks faced in terms of overdose. They aim to take a rapid access response where possible to work with clients at their optimum stage of motivation.

While this describes Islington's Better Lives service, North Central London Integrated Care Board (ICB) are going to work with Camden Better Lives to highlight this good practice.

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 Joseph, 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,

[redacted]

National Medical Director