

**Ms Penelope Schofield**  
Senior Coroner  
West Sussex, Brighton and Hove  
Record Office  
Orchard Street  
Chichester  
PO19 1DD

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

19 May 2025

Dear Coroner,

**Re: Regulation 28 Report to Prevent Future Deaths – Imogen Alice Nunn who died on 1 January 2023.**

Thank you for your Report to Prevent Future Deaths (hereafter “Report”) dated 24 March 2025 concerning the death of Imogen Alice Nunn (known as “Immy”) on 1 January 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Immy’s family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised have been listened to and reflected upon.

Your Report raised the concern that there is a lack of British Sign Language (BSL) interpreters available to help support deaf patients in the community with mental health difficulties. In Immy’s case, interpreters were not always available to attend meetings and assessments with mental health practitioners, particularly at short notice, and so they went ahead without an interpreter present.

NHS England recognises that the provision of interpreters within community mental health services is important, both to support patients and to ensure that comprehensive mental health assessments take place in a timely manner. Commissioning of community mental health services is the responsibility of [Integrated Care Boards](#) (ICBs), and this includes responsibility for ensuring that there is adequate provision of BSL interpreters to support deaf patients in the community. Should a Trust or local provider experience challenges in booking interpreters, they would be expected to identify this as a risk and work with their commissioner (ICB) to resolve the issue.

NHS Shared Business Services (SBS) have a national framework agreement in place for [Interpretation and Translation Services](#). The agreement covers all language service needs for the NHS and wider public sector organisations, with Lot 2 specifically aimed at BSL face to face, video and document services. It is not clear from your Report if Sussex Partnership NHS Foundation Trust (SPFT) were using the national framework or if there were issues with the nominated provider.

Since 1 August 2016, all organisations that provide NHS care and/or publicly funded adult social care have been legally required to follow the [Accessible Information Standard](#) (AIS), which sets out the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory

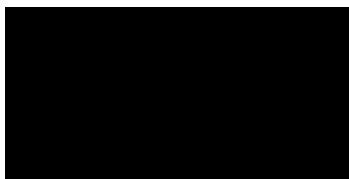
loss. The AIS was co-designed with stakeholders such as Sign Health and the British Deaf Association. A meeting will be held by NHS England later in May 2025 to brief stakeholders on the plan to publish a refreshed version of the AIS. The revised AIS is expected to ensure that BSL interpreters are suitably qualified, and that their provision is a requirement for families and carers, as well as patients.

My regional Patient Safety colleagues in the South East have also been engaging with NHS Sussex Integrated Care Board, the responsible commissioner for SPFT, on the concerns raised in your Report. They have asked for assurance from the Trust regarding reasonable adjustments being made, and are expecting a formal update from the Trust by June 2025. We are happy to update the Coroner further in this regard, if this would assist.

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 Immy, 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