NHS England

Mr Joseph Turner
HM Area Coroner
West Sussex, Brighton and Hove Coroner Service
Record Office
Orchard Street
Chichester
PO19 1DD

[redacted]

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

[redacted]

30 July 2025

Dear Mr Turner,

Re: Regulation 28 Report to Prevent Future Deaths – Sally Burr who died on 30 May 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 13 June 2025 concerning the death of Sally Burr on 30 May 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Sally's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Sally's care have been listened to and reflected upon.

Your Report raises the concern that allowing adult patients who have been detained under section, access to the internet provides an opportunity for them to be exposed to malign influences, and to obtain the means and methods to cause serious self-harm. In the circumstances, you consider that clearer and stricter rules, guidance and investment in technology may be required at a national level.

Your Report highlights the complexities of balancing a person's right to a private life, their continued connection with loved ones, enabling them to access information and support online, and adopting a least restrictive approach to their care while maintaining safety and minimising risk. NHS England's Mental Health, Learning Disability and Autism Inpatient (MHLDA) Quality Transformation Programme is working with providers of inpatient mental health settings through the Culture of Care Programme to support and improve understanding of a personalised approached to safety planning. This includes prioritising the therapeutic relationship and connection between staff and patients as a more reliable way of understanding a person's risk of harm to self and being able to collaboratively plan for ways to help keep people safe. Whilst it is recognised that some inpatient mental health settings may have to implement some blanket restrictions, we would always support a human rights based and least restrictive approach to care that is based on individual needs.

We do, however, recognise that the use of technology within mental health settings is a rapidly moving landscape and that staff need support to be able to make decisions about how to implement new technologies safely and in a least restrictive way. We recently published the Principles for using digital technologies in mental health

inpatient treatment and care in February 2025 which includes a number of key principles as well as practical suggestions for providers.

My Patient Safety colleagues from NHS England's South East region have engaged with Sussex Partnership NHS Foundation Trust (SPFT) about the concerns raised in your Report. The Trust has informed us that their internet use policy has been amended to reflect this incident, strengthening the ability of frontline staff to take organisationally supported decisions about restricting internet access / the use of phones and laptops. We have been informed that the Trust has shared this policy with yourself.

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 Sally, 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]

[redacted]
National Medical Director
NHS England