Department of Health & Social Care

[redacted]
Parliamentary Under Secretary of State for Women's Health and Mental Health

39 Victoria Street
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[redacted]

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HM Assistant Coroner Henry Charles
Coroner's Office,
Castle Hill,
Winchester,
Hampshire,
SO23 8UL

[redacted]

16 October 2025

Dear Mr Charles

Thank you for your Regulation 28 report to prevent future deaths dated 25 July 2025 about the death of Samantha Kate Young. I am replying as the Minister with responsibility for mental health.

Firstly, I would like to say how saddened I was to read of the circumstances of Samantha's death, and I offer my sincere condolences to her family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

I have noted the contents of your report, and the matters of concern raised relating to the local provision of risk assessment training for agency staff and guidelines and procedures around communications with family and friends of patients with mental health difficulties. In responding, I have liaised with NHS England and Hampshire and Isle of Wight Healthcare NHS Foundation Trust.

I have been informed by the Trust that the position in respect of agency staff and training is a complex one as agency nurses are employed by their agencies and typically do not have access to the in-house training programmes of the NHS Trusts they work at, for a number of logistical and financial reasons. However, given the specific focus on risk management arising from this case and more generally, the Trust is considering ways in which it can better support agency staff to develop in this area.

In recognition of the importance of engagement with families and carers, the Trust last year commissioned an independent audit of this area. Specifically, the purpose of the audit was to review the adequacy of the Trust's arrangements for involving and listening to families and carers so that the Trust learns from their feedback and experiences. The findings of the audit underline the Trust's commitment to ensuring

that patients' families feel heard, respected, and involved in the care of their loved ones. The findings also outline the programmes of work that are in place as the Trust

seeks to embed a culture of compassionate, inclusive care across all of its services, which include improved collaboration with partners and other organisations; improvements to its Triangle of Care initiative; and upskilling staff coaches supporting the development of colleagues to create a culture of continuous improvement and ensure person-centred care.

I understand that more detailed information about these issues, along with the key findings of the Trust's independent audit, has been provided by the Trust in its response to your report.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,