Anita Bhardwaj
HM Area Coroner
Liverpool and the Wirral Coroner's Service
Gerard Majella Courthouse,
Boundary Street,
Liverpool
L5 2QD

[redacted]

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

[redacted]

13th October 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Charles Andrew Stonley who died on 13 March 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 20 August 2025 concerning the death of Charles Andrew Stonley on 13 March 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Charles' family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Charles' care have been listened to and reflected upon.

Your Report raised concerns around the limited legal powers and resources available for mental health patients attending the Emergency Department (ED), and the detrimental impact this has on those attending whilst suffering from a mental health crisis, as well as the shortage of beds in mental health facilities.

NHS England recognises the concern that there is a lack of clarity about what legal powers are available to health professionals to forcefully detain someone in an ED who is awaiting assessment or admission. In recent debates of the Mental Health Bill, the Department of Health and Social Care committed to engage with stakeholders to understand how the current legal framework is applied in this setting and identify solutions to the problems raised. They will also provide further guidance on the existing legal framework, including the handover process from police to healthcare, in the next revision of the Mental Health Act Code of Practice.

NHS England is also taking steps to address the current operational pressures driving these issues. The NHS operational planning guidance for this year tasks local health systems to improve patient flow through mental health crisis pathways and to reduce waits of more than 12 hours in EDs. In 2025/26, the NHS is also investing £75 million in capital funding to reduce mental health out-of-area placements, which pose an increased suicide risk and lead to longer stays away from the patients' support networks.
At a local level, NHS Cheshire and Merseyside Integrated Care Board (ICB) is working with system partners to improve system flow for mental health inpatient beds. This is

focusing on reducing the length of stay and the number of patients who are clinically ready for discharge (CRFD). By reducing CRFD patients, capacity will be created to enable people to access a mental health inpatient bed in a timelier manner.

The ICB is also working with system partners on improved crisis response services, to mitigate the need for people to attend an ED for a mental health intervention. This includes providing access to crisis lines and crisis cafes.

The ICB's providers are also working with them to improve the management of people who do present to an ED with an apparent mental health need, with a focus on enhanced training and triage and reducing or eliminating 12 hour waits. To enhance this work, the next Director of Nursing meeting in October 2025 will focus on agreement of key actions that maintain the safety of patients attending EDs with mental health needs. It is intended that this will allow the development of essential actions for safety, effectively a ‘red lines’ tool kit for Mental Health Safety in EDs, and reporting of any breaches to these required actions. A red lines tool kit is a guidance document co-created by the system Directors of Nursing/Chief Nurses to agree the range of acceptable adjustments that can be made during escalating pressures and what are the hard stop ‘red lines’ that should not be crossed for risk of compromising patient safety. If any of these lines are crossed during period of exceptional service pressure an incident is raised to support a patient safety response to understand the causes and consider areas of improvement to prevent reoccurrence.

Harm reviews are routinely conducted by the ICB’s mental health providers for 12 hour waits in EDs and for CRFD patients and the learning applied to service delivery. The ICB is also developing additional physical capacity in or near to EDs for people who are in mental health crisis, creating a safe and more appropriate location for them to receive their initial assessment and intervention by a mental health professional.

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 Charles, 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
NHS England