

Joseph Turner

Area Coroner for West Sussex, Brighton and Hove
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National Medical Director

NHS England
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6th January 2026

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Joanna Chamberlain who died on 23rd January 2025.

Thank you for your Report to Prevent Future Deaths (hereafter “Report”) dated 10th November 2025 concerning the death of Joanna Chamberlain on 23rd January 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Joanna's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Joanna'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 Joanna'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 concerns that there is a gap in the provision of supportive spaces for mental health patients, who are not in immediate crisis but may benefit from more support than that provided by home treatment teams. You were also concerned that there is a need for clearer national guidance for clinicians to proactively seek views and input from family members or others in forming an immediate care and safety plan for the patient.

24/7 Neighbourhood Mental Health Centres

Six areas of the country are trialling neighbourhood mental health centres to provide community support to people with serious mental illness. The neighbourhood centres are being implemented in the following locations:

- Copeland (Whitehaven)
- Acomb (York)
- Heeley (Sheffield)
- Birmingham East Central

- Tower Hamlets (London)
- Lewisham (London)

The centres will be open 24 hours a day and 7 days a week, bringing together all aspects of community mental health services, which could include crisis services and short stay beds depending on the needs of their local area.

Anyone with serious mental health needs can drop into the centre without an appointment to receive support from psychiatrists, mental health professionals, social workers, voluntary sector workers and peer support workers.

These centres will enable people to receive psychological therapies, medication and other interventions, while also having access to expertise that can help with other important issues that may impact on their wellbeing and recovery, such as housing or employment. Evidence shows that continuity of care and being supported by the same team, who you trust and know, is critical for people's recovery in mental health care.

The centres will be run in partnership between the NHS and a range of local colleagues in health and social care, including voluntary, community, and social enterprise ([VCSE](#)) sector organisations and critically, in partnership with people with lived experience. The model of care provided through these new centres is recommended by the [World Health Organization](#).

There are also sixteen associate sites who are in receipt of the formal implementation support offer from NHS England however not additional funding. These sites include:

- Blackpool Central
- Ellesmere Port
- South Stafford
- South East Telford
- Northampton Central
- South Somerset West
- Brixham & Paignton
- East Lincolnshire
- New Parks
- Hinckley & Bosworth
- Alfreton & Ripley
- Stonebridge
- Bletchley
- North Islington
- South Leytonstone
- Portsmouth North
- Andover

Community Mental Health Framework

Since the publication of the [Community Mental Health Framework \(2019\)](#), it has been national policy that all [Integrated Care Boards \(ICBs\)](#) build stronger relationships with both local authorities and VCSE organisations as part of the wider transformation of services for people with severe mental health problems. VCSE providers are well placed within communities to provide support to meet the social needs of people with Severe Mental Illness (SMI), supporting people to manage their condition or move towards individualised recovery on their own terms in their local community. Furthermore, VCSE organisations, particularly grassroots organisations, have a key role to play in reaching previously underserved communities, thereby advancing equalities in access, experience and outcomes.

Examples of partnership working with VCSE partners include [Open Mental Health](#) in Somerset - an alliance that consists of nine core VCSE organisations, nine associate VCSE organisations, and a wider network of over 80 diverse small and micro VCSE organisations that have received small grant funding. The offer from Open Mental Health can include support around money, benefits and debt; support to be socially connected; community crisis support; 1:1 and group peer support; telephone support including a specialist service for older people and a 24/7 VCSE-led helpline; alongside clinical interventions delivered by the NHS.

Meanwhile, [Everyturn Mental Health](#) in Northumberland are commissioned by the local ICB to provide community based alternatives to crisis pathways, including safe havens and crisis beds. The service provides a practical and holistic approach to help people with a range of psychological stressors that can lead them into crisis.

NHS England published the [Staying Safe from Suicide: Best Practice Guidance for Safety Assessment, Formulation and Management](#) on 4 April 2025. It promotes a shift towards a more holistic, person-centred approach rather than relying on risk prediction, which is unreliable because suicidal thoughts can change quickly. Instead, it recommends using a method based on understanding each person's situation and managing their safety. One of its 10 overarching principles of approach is that of 'involving others: encourage the involvement of trusted others, where possible and as appropriate'. The guidance applies to all mental health practitioners and promotes the proactive engagement of trusted others within legal limits, highlighting that "in the case of immediate risk to life, the duty to share information overrides confidentiality". This guidance therefore clarifies previous national guidance.

NHS England has also launched an e-learning session, which is designed to complement our Staying Safe from Suicide Guidance. The [Staying Safe from Suicide: Best practice guidance e-learning session](#) is now available for all mental health practitioners across the country. The guidance and the training both cover sections on confidentiality and the law, and refer to the Consensus statement for information sharing and suicide prevention.

The [Medium term planning framework - delivering change together 2026/27 to 2028/29](#) also mentions that, in 2026/27, ICBs must 'ensure mental health practitioners

across all providers undertake training and deliver care in line with the [Staying safe from suicide](#) guidance.

Personalised Care Framework

NHS England has shared draft guidance with ICBs which emphasises the importance of involving a person's family, carers or support network in planning and reviewing the care for people with severe mental health problems. This 'Personalised Care Framework' includes a dedicated section on the safety planning and the management of risk (including where there are risks of harm to self).

Local Improvement Work

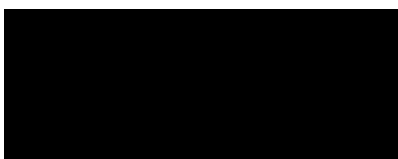
After reviewing this case, Sussex Partnership NHS Foundation Trust have outlined the work they are undertaking to improve the offer of community-based home treatment. This includes:

- Strengthening the 111 & [Blue Light Line](#) (999) services by recruiting additional staff and expanding access to senior and expert mental health practitioners.
- Establishing a 24/7 crisis response team and increasing access to [staying well services](#).
- Increasing the number of beds by commissioning short-term independent sector beds to provide immediate relief while system-wide improvements are embedded.

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 Joanna, 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,



National Medical Director
NHS England