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**17th April 2026**

Dear Coroner,

**Re: Regulation 28 Report to Prevent Future Deaths – Louis Robert Saunders, who died on 10 October 2024**

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 27 February 2026 concerning the death of Louis Robert Saunders on 10 October 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my sincere condolences to Louis' family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Louis' care have been listened to and reflected upon.

ADHD services are a complex landscape. They are commissioned locally by Integrated Care Boards (ICBs) with significant national variation existing in pathways and provision, including independent sector providers operating under the Right to Choose framework.

Your report highlights the potentially serious patient safety risk created by ineffective sharing of clinical information between care providers, in this case between a private care provider and NHS primary care. I note your reference to a shared care agreement (SCA) being put into place between the private provider and Louis' GP, following his diagnosis in October 2022 ("his care was transferred to his NHS GP under a shared care agreement").

SCAs are formal arrangements supporting the safe sharing or transfer of elements of a patient's ongoing care between, or from, a specialist provider to primary care, where this is clinically appropriate and agreed by all parties. Their purpose is to enable patients to receive continuing care in the community, while ensuring appropriate specialist oversight is maintained. Under an SCA, the specialist (in this case the private provider) initiates treatment and remains responsible for the overall treatment plan, including diagnosis, treatment initiation, and specialist review. The primary care prescriber (in this case Louis' GP) may agree to take on responsibility for routine prescribing and agreed monitoring requirements, in line with locally agreed arrangements and any national guidance.

Effective shared care relies on clear communication between the specialist and the primary care prescriber. The specialist is responsible for providing sufficient clinical information to support safe prescribing and for promptly communicating any changes

to the treatment plan, including the outcome of scheduled reviews. The primary care prescriber may seek specialist advice as required, including where concerns arise regarding treatment efficacy or adverse effects.

For medications that require ongoing specialist oversight, such as those used in the management of ADHD, SCAs are typically time-limited and subject to regular specialist review. Overall clinical accountability for the patients care remains with the specialist, while specific elements of care are delivered under shared care arrangements: the specialist retains responsibility for diagnosis, treatment initiation, specialist review and any material changes to the treatment plan, and the GP undertakes agreed aspects of prescribing and monitoring in line with the SCA. The patient therefore remains under the care of both the specialist and the GP throughout. Where a material change to treatment is proposed, a revised or new SCA would normally be required, subject to the agreement of the GP.

I understand from your report that the SCA was established for the provision of Lisdexamfetamine (30mg) to Louis, and the first prescription issued by his GP, in November 2023. However, concurrently, Louis was reviewed by his specialist and his pharmacological treatment changed to Dexamfetamine (5mg, 3 times daily), resulting in simultaneous prescriptions. It is not unusual for a brief overlap in prescribing to exist when a treatment change occurs in the background of an existing SCA. Normally we would anticipate that the private provider (as the responsible specialist) would have discussed with Louis that this change of medication meant he should no longer take the Lisdexamfetamine prescribed previously and communicated the change in treatment plan to Louis' GP, in order that they could discontinue the existing Lisdexamfetamine prescription.

We understand the concern that has arisen relates to continuity of care and robustness of process between private providers and the NHS once a patient has been diagnosed with ADHD, commenced on medication, and subsequently transferred to GP care. However, I want to reassure you that it is entirely appropriate for a patient receiving ADHD medication via an SCA to remain under the care of their responsible specialist alongside their primary care prescriber, due to the need for the responsible specialist to retain oversight and manage treatment in line with the evolving needs of the patient. I have fed your concerns back to NHS England's National ADHD Programme and Primary Care Teams, who will ensure that the risks you have raised of duplicate prescriptions and confusion between current and previous medication regimes, and actions you have identified, including the need for continuity of care and timely and effective communication of treatment changes, are highlighted to both specialist providers and primary care prescribers wherever possible in their ongoing work.

NHS England is committed to working with system partners, including commissioners and providers of ADHD support, to improve health-related experience and outcomes for those with ADHD. We recently published non-mandatory guide prices for ADHD assessments and treatment pathways, alongside detailed commissioning guidance, that will set clear expectations for assessment standards, data quality, clinical governance, shared care and follow-up.

More fundamentally, the government has commissioned an Independent review into mental health conditions, ADHD and autism to look at the issues relating to assessment and diagnosis you have raised. In parallel to the Review, we are also

conducting an internal exercise to understand current NHS clinical and operational practice and spend on mental health, autism and ADHD services. In addition to identifying unwarranted variation in service models, we will explore how we can improve access, productivity and quality of NHS services with a range of experts. To inform local commissioning and provision of care, we will use our findings to set out clear proposals for the future of mental health, autism and ADHD services.

It is also important to reaffirm the national commitment to suicide prevention. NHS England and the Department of Health and Social Care continue to prioritise improvements in early identification of suicide risk, safe prescribing, timely access to psychological support and joined-up communication across organisations. These priorities are reflected in the national suicide prevention strategy, which places particular focus on young adults and people with neurodevelopmental conditions, groups recognised as facing disproportionately high risks.

**Regional Response**

The South East Regional NHS England Team have liaised with the NHS GP practice and the private ADHD clinic regarding this case.

The NHS GP practice have held multiple practice meetings looking at their in-house systems around SCAs for their patients with ADHD. Through this they identified difficulties with communication between themselves and the private provider which meant that the practice were not fully aware of what treatment Louis was receiving. They also noted difficulties in being able to contact the private clinics due to problems both with finding a point of contact and receiving a response.

The NHS GP practice highlighted that with SCAs used for other medications there is a clear standardisation of what is expected from general practice and secondary care. They would welcome improved communication with private providers and greater clarity around the specifics of an ADHD shared care agreement.

The Region have liaised with the private ADHD clinic who have advised that they have held a formal preventing future deaths review meeting for this case. The result of the review was that they did not identify any deficiencies in their processes, nor any changes required to their current clinical practice. They highlighted their current systems ensure continuity of care and safer prescribing which included that following every clinical interaction, including titration, medication reviews, and shared care reviews, detailed written correspondence is issued to the patient's GP to ensure continuity, transparency, and clarity of care. They clarified that they do not initiate medication without first obtaining a Summary Care Record or equivalent clinical information from the patient's GP.

The Region will be sharing the responses from the NHS GP with the private provider and the private providers response with the NHS GP so they are aware of each other's response. If you have any further questions we would advise you address those to the private provider directly.

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 Louis, 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,

Medical Director for Mental Health and Neurodiversity

NHS England