Mr David C Horsley LLB, Solicitor
Her Majesty's Coroner for
Portsmouth and South East Hampshire
The Coroner's Court
1 Guildhall Square
Portsmouth
PO1 2GJ

Wellington House
133-155 Waterloo Road
London
SE1 8UG

6th June 2019

Dear Mr Horsley

Regulation 28 Report – Mr Ronald CLARK

Thank you for the Regulation 28 report dated 8 April 2019, that was received on 23 April 2019. Although your report was directed at NHS Improvement, NHS England and NHS Improvement have been operating as a single organisation since 1 April 2019. This response is provided in my capacity as the National Director of Patient Safety, NHS Improvement.

I am grateful to you for sharing your findings from the inquest with us and highlighting that actions could prevent future deaths. The main action that you highlight relates to changes to manufacturer's packaging so that different-sized stents are in different-coloured packaging. I note that the Regulation 28 report has also been sent to the Medicines and Healthcare products Regulatory Agency and, as changes to packaging falls within their remit, they are the more appropriate body to respond on this specific action.

The related action that I have been able to take, to reduce the potential for such incidents from happening again, is detailed below.

The National Patient Safety Team, being part of NHS Improvement, is in the process of reviewing the National Safety Standards for Invasive Procedures (NatSIPPs). These are a set of high-level, national standards for all invasive procedures that have been produced to support local providers in developing and maintaining their own more detailed standardised local procedures and in order to reduce the likelihood of Never Events occurring.

The NatSIPP on prosthesis verification is being updated to reflect developments in implant selection and verification processes and will include the potential for future scanning for all prothesis/implants.

I hope you will be able to share my reply with Mr Clark's family. I was very sorry to hear that this error occurred, and I hope it will give the family some comfort that we are taking steps to prevent this type of error in future.

I trust that you will find this information of assistance and should you require any further detail, please do not hesitate to contact me.

Yours sincerely,

Dr Aidan Fowler, MBBS, FRCS

National Director of Patient Safety

NHS Improvement