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HM Senior Coroner for West Yorkshire (West)
HM Coroner's Court
Cater Building
1 Cater Street
Bradford
BD1 5AS

16/06/2022

Dear Sir,

RE: Faizan Nazir

Response to Regulation 28 Report behalf of Spire Harpenden Hospital

I write to you today in response to a Regulation 28 Report dated 4 April 2022, addressed to Spire Harpenden Hospital.

As you are aware:-

- Spire Harpenden was not afforded Interested Person status at the inquest;
- Spire Harpenden was never contacted by your office about the tragic death of Mr Nazir and did not attend the inquest;
- At no point was Spire Harpenden asked to provide any evidence or information to the Court prior to the conclusion of the inquest.

Notwithstanding the same, following evidence heard by the Consultant Psychiatrist treating Mr Nazir on a private basis via Spire Harpenden Hospital, you issued a Regulation 28 Report in which you expressed concern in the following terms:-

"[Mr Nazir's Consultant Psychiatrist] told me that it was not customary at Spire Harpenden Hospital to forward written reminders of a patient's forthcoming appointments. In my opinion there is a risk that future deaths could occur unless action is taken."

We would like to make it clear from the outset that as a leading healthcare provider we take the issuing of any Regulation 28 Report very seriously. A Regulation 28 Report, once issued, is not limited in scope to the Coronial process. We understand that the Coroner also provided a copy of the Regulation 28 Report to the CQC as our Regulator, who requested further information, which we can confirm has already been provided separately. A Regulation 28 Report also prompts internal action as part of our own clinical governance and as part of ongoing consideration as to how systems can be

improved for the benefit and safety of our patients. Further, as an organisation we recognise that the tragic loss of Mr Nazir coupled with concern expressed by the Court as to the systems in place at the time may have compounded the family's distress. We would therefore wish to pass on our sincere condolences to the family and greatly regret that we were not provided with an opportunity to address these concerns from the outset at the inquest itself when we could have provided clarity for you and the family.

Having now had an opportunity to consider the recording of the evidence that was provided to the Court, we believe that the concern expressed in the Regulation 28 Report is factually incorrect. At no point during his evidence did [redacted] state that it was not customary to forward written reminders of a patient's forthcoming appointments. Had he stated as such, this would in any event have been incorrect (for the reasons we have set out below).

It is of serious concern to us that a Regulation 28 Report was issued without being properly grounded in the evidence provided to the Court. I have taken legal advice about the matter, and I understand the position to be as follows:

- Under Regulation 28(3) of the Coroners (Investigation) Regulations 2013 it is a pre-condition to issuing a Regulation 28 Report that all the documents, evidence and information that the Coroner considers to be relevant to the investigation must be considered. Whilst we recognise that it is for the Coroner to consider which evidence or information is relevant to the scope of the inquest, in circumstances where there was concern as to the system but no current evidence as to the system in place at an organisational level, we consider that it would have been appropriate to seek such evidence prior to conclusion of the inquest and in any event prior to the implementation of statutory powers.
- We are concerned that there was a lack of proper regard as to the Chief Coroner's Guidance in relation to the issuing of a Regulation 28 Report. For the avoidance of doubt, unrelated to these events, [redacted] has moved his private practice and no longer practises at the Spire Harpenden Hospital.
- Paragraph 28 of the Guidance states that Coroners should be careful, particularly when reporting about something specific, to base their report on clear evidence at the inquest and to express clearly and simply what that information or evidence is. Again, this did not occur as we consider that the Regulation 28 Report does not accurately reflect the evidence that was in fact given by [redacted]

We therefore consider that we ought to have been offered the opportunity to make representations and/or provide evidence <u>prior</u> to your implementation of your statutory powers. We consider it unlikely that a Regulation 28 Report would have been issued in the terms expressed had we been invited to make representations or provide evidence to the Court from the outset.

Notwithstanding the above, we do recognise that there was evidence provided as to whether there was any system in place to remind a privately paying patient of a clinician's recommendation to arrange a follow-up appointment (the same being a factually different premise to that set out within the Regulation 28 Notice). We recognise that, without further explanation from Spire, the same may give rise to concern. In the circumstances, and coupled with the need to address the concern actually

expressed in the Regulation 28 Report, we confirm that the current systems in place at Spire Harpenden Hospital with regards to arranging appointments are as follows:

a) Process for making an appointment with a consultant

As is industry standard, Consultants at Spire are not employed but practise on a self-employed basis, under practising privileges. Patients' appointments are typically booked via a consultant's private secretary. It is noted that Mr Nazir was able to effectively use this system and that he made appointments with [redacted] via his secretary on more than one occasion. It should be noted that Spire is not responsible for the diaries of individual Consultants with practising privileges at the hospital. This responsibility lies with the individual clinician, and they make their own arrangements for diarising appointments with their secretary. Once a patient has decided they wish to book an appointment, the same is confirmed with the clinician and then entered onto the Hospital's system. Patients can also make appointments by directly contacting the hospital, but in Mr Nazir's case all his appointments were made via [redacted] secretary.

b) Process for sending reminders of an appointment that has been made

Once an appointment has been confirmed on the hospital management system as above, a patient will receive a confirmation of appointment via letter and a text message is sent to a patient 48 hours in advance of the date itself to remind them of the upcoming appointment. The purpose of sending a reminder in these circumstances is to avoid missed appointments that have already been booked by the patient which was not the case in this situation as Spire was not made aware by the consultant of his request to Mr Nazir to book an appointment. We can confirm that no issues have therefore been identified with Spire's system, and it is noted that Mr Nazir did not miss any appointments that he had in fact booked with [redacted]

c) Process for sending reminders to make an appointment that has been recommended by the Consultant but not then booked by the patient.

It is our understanding that, notwithstanding the concern as expressed in the Regulation 28 Report, it is the above scenario that was in fact considered during the course of the inquest. Dr [redacted] had recommended a follow-up appointment in 6-8 weeks. Following his consultation in May 2021, [redacted] did not then take any steps to ascertain whether Mr Nazir wished to book a further appointment nor was any reminder to book a further appointment sent to Mr Nazir. No further appointment between [redacted] and Mr Nazir was arranged after May 2021. Therefore this tragic case does not relate to a situation where a patient had booked an appointment with Spire and had not attended that appointment, but rather it relates to a situation where Spire was not made aware, by the consultant, of his request to a patient to arrange a follow up appointment. The examination therefore of any system (if appropriate) would properly be that which concerned the consultants' arrangements for following up patients who failed to make contact despite advice, and notifying the patients' GP if they failed to respond.

If a follow-up appointment is recommended by a clinician, our expectation as an organisation is that the same is clearly communicated to the patient (either verbally or in a clinic letter or both) in line with a doctor's professional obligations. What action is then taken to follow through with that recommendation would, of course, rest with the individual patient, supported by guidance from his consultant and GP.

We trust that any concerns have now been allayed and any misunderstandings now rectified.

In the circumstances, we would invite the Court to consider whether the Regulation 28 Report ought to be withdrawn given that the same was issued on an incorrect evidential basis as set out above. Insofar as we are aware, there is nothing within the Coroners and Justice Act 2009 or the Coroner's (Investigation) Regulations 2013 that directly prohibits a Regulation 28 Report being rescinded and such action would appear to be appropriate if the factual basis upon which the same was issued is incorrect.

Yours faithfully,

[redacted]

[redacted]
Group Medical Director