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1 August 2022

Dear Professor Wilcox

Regulation 28 – Report to Prevent Future Deaths 9 May 2022 (St George's Cardiac Surgery)

I write to provide a response to the PFD report issued following the inquest into the death of Raymond Griffiths, dated 9 May 2022. Whilst I write this response in my capacity as National Medical Director, it is in fact the response on behalf of NHS England and, since 1 July 2022, its predecessor entities including NHS Improvement who commissioned the Independent Mortality Review your PFD report refers to.

In order to ensure this response is a fair reflection of the position for cardiac services we have liaised closely with St George's University Hospital NHS Foundation Trust ("the Trust"). Our response will signpost you to the Trust's response, particularly where we will rely on information provided by them, as they are the providers of the cardiac service in question and frontline to protecting their patients' safety. Our response should be read in conjunction with the Trust's response, given the overlap in a number of areas.

Introduction

In order to respond, we have revisited the history of matters at St George's cardiac services as known to us, and which led us (through the London Region of NHS Improvement) to commission the Independent Mortality Review of Cardiac Surgery at St George's University Hospital NHS Foundation Trust ("the Review"), about which the PFD report is critical.

We have structured this response in three parts:

1. **Current patient safety – cardiac services**
   First we will update you on the current position of cardiac surgery services at the Trust, as it is known to us, to ensure you have an accurate picture on how cardiac patients' needs are being safely met across London and beyond, and to respond to your concerns as to current and future patient safety. We consider this is the most important element of your PFD, and central to any PFD purpose;

2. **The Review**
   Next we will consider the context of the review, the process by which is was undertaken and its output;

3. **Section 5 – Matters of Concern**
   Finally we will respond to each of the matters of concern that you raise in section 5 of the PFD, in turn. Where appropriate, we will refer to the Trust's response on matters where they are best placed to add detail and assurance on patient safety.

We hope that this response is of assistance in understanding the current patient safety position at the Trust's cardiac unit. It will also confirm why, in our opinion, the Review was appropriately commissioned and provided a useful contribution to the Trust, who adopted the recommendations as part of their management of patient safety concerns and made key changes to how the cardiac services team functions. We trust that this will assure you, and the public, that no patient safety risks have been created by the Review chaired by [redacted]

1. <u>Current patient safety – cardiac services</u>

The Trust's PFD response provides detailed chronology and reasoning for the restrictions placed by the Trust on cardiac surgical practice in August 2018, following the second NICOR alert. In the lead-up to those restrictions being implemented, the Trust had received expressions of concern, in a variety of forms, from different sources such as the Care Quality Commission, Health Education England, NICOR, Dr [redacted], the Getting It Right First Time (GIRFT) data, and internal 'whistleblowing' reports. In our view, public confidence had already begun to deteriorate following national media attention of the NICOR alert and the Bewick Review. The Trust had also encountered challenging data regarding increasing Surgical Site Infections in the unit which needed addressing. Collectively, this data and feedback raised significant concern about the cardiac unit services.

As a result, restrictions were formally agreed by stakeholders including NHS Improvement, the Care Quality Commission (CQC), NHS England, Health Education England (HEE) and the General Medical Council (GMC). These stakeholders along with local peer NHS Trusts, such as Kings College Hospital (KCH) and Guy's & St Thomas' NHS Foundation Trust (GSTT) also formed a Single Item Quality Surveillance Group (SIQSG) to ensure close and regular scrutiny of patient safety and outcomes in the service.

Even with the restrictions in place, the Trust's cardiac unit continued to provide cardiac surgery to patients in South West London. More complex cardiac surgery with greater risk of mortality was undertaken in neighbouring NHS Trusts, as described in the Trust's PFD response. The restrictions were lifted in April 2021, with agreement of the stakeholders mentioned above.

There has been no restriction on the level of planned complex cardiac surgery that can be carried out in the Trust's cardiac surgery unit since 2021. To support the cardiac unit on its return to business as usual, the Trust, with agreement of the same group of stakeholders, provided operational support such as dual consultant procedures, mentoring and sub-specialisation in operating.

The Trust's response brings matters up to date, with those temporary supportive measures about to be removed, again with the agreement of the core group of stakeholders, including regulators and professional bodies. The Trust's PFD response provides additional data on outcomes, with assurance on quality and safety being maintained during the period of restrictions, with external scrutiny including the CQC and NICOR evidencing positive safety and quality, contrary to the concerns raised in the PFD report.

It can be seen from the timeline set out by the Trust, that the restrictions were agreed and implemented *before* the Review was commissioned, rather than in response to it. This is a crucial point with respect to the concerns raised in the PFD that the Review has resulted in the creation of current patient safety risks.

Cardiac surgery has significantly evolved since the restrictions were put in place in August 2018. Indeed, as with most elective surgical specialties, the temporary pause during the initial impact of the Covid pandemic, provided an opportunity to reset and refocus surgical practice and procedures. We believe the support provided by the stakeholders to the Trust over the past few years has resulted in a more collaborative approach to cardiac surgery in South London. KCH, GSTT and the Trust meet regularly and are committed to work closer as part of the South London Cardiac Surgery Network benefiting patients, promoting patient choice and patient safety. This same network has also continued to regularly consider

demand and capacity of the system, both during the restrictions period, and on an ongoing basis. NHS England will continue to support the Trust as this network evolves further.

2. The Review

a. Context of the Review

As described in detail in the Trust's PFD response, and referenced above, the Trust's cardiac unit was under considerable scrutiny before the Review was commissioned by NHS Improvement and Terms of Reference agreed in November 2018.

As you are aware from our letter to you dated 16 December 2020, and in accordance with statements within the public domain, the reason that NHS Improvement (now NHSE) commissioned the Independent Review was because of serious patient safety concerns that had been identified in cardiac surgery at the Trust by a number of different sources as mentioned above. There had also been significant public and media attention focused on patient safety concerns at the cardiac surgery unit at St George's Hospital, and the Trust's response details the cumulative concerns from that period. It was for the same reason that the Panel members, all experienced independent experts in their fields, agreed to give up their time to assist in this review process; a decision that was fully supported by their NHS employers given the importance of ensuring public safety and confidence in NHS services as a whole.

The Review was commissioned to maintain or improve the quality of the services and in order to protect and promote the interests of people who use health care services by promoting provision of health care services which are economic, efficient, safe and effective. We note the primacy of the interests of patients. The Review was also to confirm whether the Trust, not any individual clinician, had addressed the issues raised through NICOR alerts and to inform any subsequent discussions that may or may not be needed with you as the coroner in whose jurisdiction the deaths occurred. We note the Trust's PFD response addresses in detail the sequence of concerns as they evolved, and the impact (and corrected interpretation) of the NICOR alerts, as in our view the PFD report is inaccurate in its portrayal of that element.

It is our opinion, in light of the numerous sources of concern described by the Trust's response, that commissioning the Review was an appropriate response to the sequence of events and concerns at that time. We would have anticipated concerns being raised with NHS Improvement and the Trust had either organisation not taken steps to investigate and manage patient safety risks and the mounting public concern at the time.

b. Process of the Review

The purpose of the review was to take a holistic view, not just of the cardiac surgery but across the multi-disciplinary support a patient needs in order to carry out cardiac care. The Review was undertaken by a panel of experts from across the country including surgeons, cardiologists, intensivists and anaesthetists.

The Review panel conducted a structured judgement review ('SJR') of each case in scope, applying the National Mortality Case Record Review (NMCRR) programme resources of the Royal College of Physicians and the "Michigan" method to evaluate cardiac surgery mortality by analysis of the individual phases of care published in the Annuals of Thoracic Surgery. As the patient numbers grew, the methodology for the clinical reviews underwent several iterations, with the process more efficiently managed once the bespoke electronic platform had been built. Each of the family cases was reviewed, discussed and graded in accordance with the methodology agreed. The clinical care was graded using a long-established scoring system developed by the

University of Leicester which was also used in the Report of the Morecambe Bay Investigation (2015) by Dr [redacted]

The PFD suggests that only limited feedback from the surgeons involved in care was sought. We can confirm that the surgeons and referring cardiologists were sent the draft SJRs for each patient and invited to comment, particularly on factual accuracy. A number of clinicians submitted substantial volumes of additional material in response in November and December 2019. Over a number of days across a 3 month period, the panel reconvened, reconsidered each case in which additional material had been submitted and made changes to the SJRs where it considered that appropriate. The panel worked by consensus, recording their reasons, and allowing for a factual accuracy check before the Review was published in March 2020. In our view it is not the case that there was a lack of opportunity to respond within the process of the Review.

The opinions expressed through the Review were made in good faith by the panel of experts. The review findings were subsequently appropriately and transparently brought to your attention. This transparency was intended to enable you, as Senior Coroner, to make your own decision as to whether any deaths required further investigation, and if so, the scope of that investigation, and whether inquests were ultimately required.

c. <u>'Recurring Themes'</u>

The PFD lists a number of recurring themes which are expressed as being of concern. We trust the following responses to each of these will be of assistance:

- ***Each review was undertaken solely on an examination of medical records of SGH given to the panel by SGH.***
  This is correct – the Review was a desktop review based on the St George's Hospital records provided to the panel at the time;

- ***These records were often incomplete and rarely included evidence from hospitals referring patients in to SGH, so called feeder hospitals, including the results of pre-operative investigations and multidisciplinary team meetings (MDTs), that had occurred within the feeder hospitals.***
  It is correct that the Review panel only had available to them clinical records provided by the Trust for this desktop review. Where a referral to a centre is made, the referring hospital's clinical referral information would form part of the records for the Trust, but this would not include (for any tertiary referral arrangement nationally) the receiving hospital accessing the entire clinical records of the referring hospital. It is therefore correct to state that the 'feeder' hospital records would not have been available to the Review panel, save for a referral letter/note. It is not clear to us whether this is the basis on which the PFD suggests the St George's records were "rarely complete", or whether this is a more general comment about (a) the completeness of St Georges' records generally, (b) the completeness of St George's records in this particular cohort, or (c) the adequacy of documentation shared with the Review panel. If the latter, our comment on process reflects that the surgeons and cardiologists were able to share any additional material with the Review panel when they saw the draft SJRs, to ensure visibility of any missing evidence. As you will be aware, where matters may not have been documented, this can of itself, create a safety concern.

- ***No statements, no discussions nor any other input was allowed or considered as part of the SJR process from any clinician, technician or nurse who was involved in the patient's care. Even where missing notes were later identified these appear not to have been considered.***

- ***Some SJRs contain logical inconsistencies, for example finding that a matter may have contributed to the death in one section of care looked at, but the final conclusion then stating that failures in care definitely contributed to the death.***
- ***The SJRs repeatedly make adverse inferences in the absence of evidence, leading to erroneous findings of failures. For example that MDTs did not place, or appropriate investigations were not carried out.***
- **Some SJRs have misinterpreted investigation findings.**
  Responding to the above collectively, we have clarified in this response that the affected surgeons and referring cardiologists had the opportunity to consider the SJRs, contribute further information and documentation surrounding the care provided to the individual patients and contributed to factual accuracy amendments made before the report was finalised. We also understand the Review relied on the primary record of an MDT, where this was available. A secondary record (without any primary record) for example a reference to an MDT in a discharge summary written after the patient had died, was regarded, by the Review Panel, as potentially less compelling. In our view such matters reflect the exercise of professional judgement by expert panellists.

- ***Only the cardiac surgeons were allowed to give any feedback. This was limited to written response for each case in which they had been the main operating surgeon. This feedback had to be completed within a strict 2 week time frame and was mostly ignored.***
  The surgeons and referring cardiologists had full visibility of the SJRs for cases where they were involved and were able to collate significant responses and material that was submitted to the panel. This was initially a 2 week period for response, but extensions were granted where requested. As mentioned above, full consideration of their opinions and additional information provided was given over a number of days across a 3 month period. This resulted in updates made to the SJRs, factual accuracy checks and reconsideration of opinion where appropriate. We do not agree with the suggestion in the PFD that this feedback "*was mostly ignored*"..

- ***No other feedback was allowed, even where there were criticisms of non surgical care such as cardiology or intensive care, nor even where the panellists stepped outside their own areas of expertise to criticism areas such as intraoperative perfusion.***
- ***Some SJRs criticise areas of expertise outside the expertise of the panel, for example, perfusion.***
  Again, collating the elements of concern above; we do not consider that the panel exceeded their professional expertise in their analysis of the cohort of cases, based on what they were asked to consider and the opinions they gave. Taking intraoperative perfusion as an example, in our view it is not necessary to engage a perfusionist, as a technician, to provide surgical comment on a clinical case. Perfusionists are highly skilled and valued members of the multi professional team that care for cardiothoracic patients, but decisions related to perfusion are also made by surgeons and anaesthetists.

- ***The SJRs took between 10-20 mins of panel consideration of notes for the simpler cases, with the most complex requiring 2-3 hours. This time spent is negligible compared to the time spent investigating and hearing these cases by the coroner's court.***
  In our opinion the time spent reviewing each set of clinical records for the Review is not relevant to the clinical expert opinions expressed in the Review. Nor does it invalidate those opinions. We would however note that the panel often consisted of 7-8 experts, and therefore (even ignoring the synergy of multiple workers on a particular problem), the collective time spent on cases was more than is portrayed here.

SJRs in healthcare operate as a useful and well-established process to reflect on care provided and to identify learning and areas for improvement. SJRs therefore have a separate 'jurisdiction' and purpose; and would never seek to offer an alternative or duplicative analysis when compared to the coronial process.

The Review was a desktop review, and this inevitably has to make a judgement based on material that is available at that time. A number of concerns reflected the absence of documentation of care decisions, and where the surgeons provided feedback to include missing documentation, the Review panel took this into account, albeit assessing the relative value of primary and secondary sources of evidence of decision making. Where the Review panel did not see documentary evidence of key steps or decisions, or discussions with other specialists, it had to form conclusions based on what the available records demonstrated. This is not an unreasonable approach for a desktop review of this nature and reflects sector 'norms' involving historic care reviews (for example, invited Case Reviews and invited Service Reviews by the Royal College of Surgeons).

- ***Some SJRs contain pejorative subjective comments for which there has been no foundation in evidence, appearing to echo comments of previous reviews looking at professional relationships, for example 'silo working'.***
  Comments regarding silo working were views formed by the panel as part of their review process.

- ***Some SJR findings have been contrary to the European Guidelines in force at the time.***
- ***Some SJRs apply 2018 standards and systems of care to cases for example in 2013 when other standards applied.***
  In relation to applying the clinical guidelines that were relevant to the time at which the patient was seen, the panel was mindful throughout the Review of the need to align guidance with timelines for care provided.

d. Outputs from the Review
The Review was shared with the Trust, and with the SIQSG. The recommendations were accepted by the Trust and actioned.

The list of consequences described in the PFD implies these are consequences of the Review in isolation, which is chronologically incorrect, as advised above, and also evident in the Trust's response. We are concerned that your statement that there has been "*no evidence that this court has so far seen of deficiencies in care*" appears to significantly overstate the position at the Trust and also contradicts the reference to a case already heard by the Coroner where concerns regarding the care were established at inquest too (see page 4 of the PFD).

We accept that one of the consequences of the Review was the reporting of its findings to you as the relevant Coroner, and also to a stakeholder group.

In terms of impact, we are not aware of any evidence to suggest that the Review, or any action taken in response to it, has resulted in any patient coming to harm, or indeed death (as stated in your paragraph 5 – see further below). The PFD response from the Trust provides further detail regarding the absence of any connection between the Review and additional safety issues flowing from actions taken by the Trust in response to the Review.

The PFD dated 9 May 2022 does not provide any detail of patients said to have been harmed (fatally, or otherwise) and leaves us unable to explore that issue further. Should you have evidence to the contrary or data indicating that this needs further investigation, we would respectfully ask that you disclose this to us so that appropriate action can be taken.

e. Referral of cases to HM Coroner

We recognise the additional work that has resulted from decisions you have then made with regard to reopening inquests, and the inevitable distress that families will have experienced by having to go through an inquest process. It is however difficult (in context) to see how a desire to be transparent about opinions received regarding care of a patient prior to their death, should be criticised. We also understand that you publicly accepted, at the conclusion of the inquest into Mr Griffiths' death, that it had after all been a suitable case for an inquest.

The benefit of the inquisitional process of an Inquest means that a wider range of opinions, investigative time and powers of disclosure from third parties can support a coroner to determine how the deceased came by their death. It is certainly possible that the conclusion of a coroner at the end of an Inquest may differ from a separate process such as an initial mortality review, an independent holistic review or a statutory incident investigation. However, just because it differs, does not mean that another panel's opinion holds less validity, nor that it creates, if itself, a (separate) patient safety issue. We believe a difference of opinion is conceivable given the different 'jurisdictions' and different methodologies the two processes apply, different evidence received, and interpretation of that evidence, through different lenses. The processes are conducted within different time periods in which to conduct the respective analysis and ultimately with a very different intended purpose.

f. Impact of Criticism by HM Coroner

We are concerned that the 'finding' in the background section of the PFD with regard to the number and complexity of cardiac cases performed in Brighton, where the Chair of the Review panel ([redacted]) is employed, could be interpreted as a questioning of the credibility of [redacted] professional opinion. It also references no basis of established fact or data to support the assertion.

As we have highlighted the Review was not the opinion of one clinician, but the combined opinion of the panel, with the significant combined clinical experience held between them. Regrettably, the continued personal focus on [redacted] has produced highly intrusive and potentially detrimental media coverage, impacting him and his family, and also providing inappropriate context to his care of patients as a Cardiac Surgeon in Sussex. In our view inferences, potentially disparaging, made about [redacted] as a clinician, who voluntarily contributed to and Chaired the Review into patient safety concerns are inappropriate.

As you will no doubt appreciate, given your own important role in the patient safety sphere, it is of the upmost importance to not only ensure that the appropriate standard of care is provided in our healthcare system but also that the public have confidence that when patient safety concerns are identified, these are investigated and steps taken to ensure the safety of all those using the service. Such concerns can arise through direct clinical outcomes concerns, or indeed as a result of a service that has become less effective (and often therefore less safe) due to dysfunction within teams. Communication and team working go hand in hand with maintaining patient safety and where concerns arise, it is right to ensure those are explored and recommendations made to achieve continuous improvement in the safety of patients.

NHSE has endeavoured to involve you as HM Senior Coroner throughout the Review process, ensuring that you were aware of the terms of reference agreed in November 2018 and the methodology that the Panel would be adopting. To now receive public dismissal within a PFD report of the work of the independent panel of experts and the methodology undertaken is disappointing.

g. Specific elements of PFD (where not addressed elsewhere)

We take no issue with sections 1 – 3 from an accuracy perspective. We were not involved in your investigation into the death of Mr Griffiths which concluded with a hearing on 31 March 2022, nor invited to contribute in any way. We note Mr Griffiths sadly died as a result of acute liver failure 3 days after cardiac surgery. We note you have concluded he died from "natural causes contributed to by recognised complication of essential surgical treatment".

We would however note that the Trust's Mortality and Morbidity review (a standard post death multi-disciplinary meeting to reflect on care and identify learning) considered it would have been advisable to engage earlier with a hepatologist to provide opinion on Mr Griffiths' liver function in the presence of established cirrhosis. The Review also recommended a further discussion within an MDT setting. We are unaware whether the Court had the benefit of any hepatology evidence when arriving at conclusions in this case.

Further in Mr Griffith's case, the PFD states that "*all the criticisms of care made within the SJR were unfounded and that the conclusion of the SJR, that failures in care had probably contributed to the death, was simply incorrect*". You are of course entitled as Coroner presiding over an inquest, to make a number of factual findings as required by statute within the remit of the role of a Coroner. Here however, we are concerned that you seek to neutralise the professional opinion of a panel of experts who have (within clearly identified caveats) expressed opinions in good faith. You are entitled to form a conclusion as to how the deceased came by his death.

In our opinion, we do not consider it is correct to simply dismiss as "incorrect" a professional opinion. You can of course prefer one piece of evidence over another, in terms of weight that you give it. But in so doing, there remains a need to balance the evidence available.

3. Section 5 – Matters of Concern

i. Restriction of cardiac surgical capacity is causing patients to be diverted to other overstretched units, increasing their risk of death

We defer to the Trust's detailed response regarding the paucity of incidents arising from the diversion of patients linked to restriction of cardiac surgery capacity. As commissioners, we are unaware of any specific deaths arising from the clinical pathways arrangements for patients during the restrictions outlined earlier in this response. The Trust has described a single emergency care incident in which the restrictions were found to have been one of a number of factors that may have delayed care. We would welcome established facts and corresponding data and evidence from you, if this is the case, so that we or the Trust may investigate further.

ii. Diversion of emergency patients has resulted in unnecessary deaths

We again defer to the Trust's PFD response, which provides detailed assurance on this issue.

iii. Public confidence has been dented such that patients are discouraged from presenting at the Trust thus increasing their risk of death

Any loss of confidence in services would be regrettable. However we would observe, as commissioners of services across London, that if patients requiring cardiac surgery do not wish to present to St George's Hospital, there are other local centres within the cardiac surgery network which have eminently capable cardiac surgery units, to which patients can present or be referred. We are not aware of any tangible data to support the suggestion that "patients are discouraged

from presenting at STG thus increasing their risk of death". We also note that, if there was any speculation of public confidence being dented, this would have occurred before the Review given the significant widespread negative media attention following the NICOR alerts, the CQC inspection and Bewick review.

iv. An Inadequate and critical SJR process has failed to identify learning to improve patient safety and prevent future deaths

We do not agree that the SJR was inadequate as a process, nor that it failed to identify learning to improve patient safety. The objective evidential basis for this comment is unclear. The Review identified and acknowledged good practice; and it made 12 positive recommendations which were aimed at improving governance and patient safety (and therefore reducing the risk of patient deaths). The Trust's PFD response acknowledges the assistance provided by the reasonable recommendations made by the Review, which the Trust has acted upon to drive improvements in service. We also understand that the surgeons, cardiologists and anaesthetists held individual discussions with Review panel members following the Review being completed, and they accepted the recommendations made by the Review panel.

v. The SJR process undermined the department unnecessarily, impacting morale and mental health of clinicians at the Trust which may translate into lower quality of care for patients

We defer to the Trust's response to the PFD to address this concern, as it reflects a local response to supporting the wellbeing of clinicians and Trust staff generally, and specifically in relation to maintaining patient safety. We are unaware of any objective evidence to suggest that the Review has caused a lower standard of care being provided to patients, and indeed the Trust's subsequent CQC inspection, recent visit by HEE and good mortality outcomes detailed in the Trust's PFD response all objectively evidence assurance of safe care. We would be grateful if you would provide any evidence of a lower quality of care being provided, in order that either NHSE or the Trust can investigate this further and offer further support, if needed.

vi. The restrictions were "apparently unnecessary" on the operating rights of cardiac surgeons and is reducing the overall capacity; thus may increase the risk of death "as they die on waiting lists"

We have been unable to identify the evidence base for this concern. For the reasons outlined in significant detail the Trust's response, it was clear that the restrictions put in place were necessary and proportionate in response to serious concerns raised and investigated, prior to the commissioning of the Review referenced in the PFD report. These concerns arose from multiple different sources prior to the Review, and we believe that as a matter of public confidence, both commissioners and providers must respond to concerns and protect and promote patient safety.

We would also note that there is a long-standing regional cardiac surgery network which is well equipped to accept patients who, under previous restrictions, were not accepted at St George's. Those restrictions were lifted in April 2021. Supportive measures were put in place following the return to business as usual on the cardiac unit (bearing in mind cardiac care had evolved considerably with an increasing national movement towards subspecialisation in the interests of better patient outcomes). As commissioners, we are unaware of any evidence of an increased risk of death based on waiting list delays arising specifically from the impact of the Review, or the appropriate restrictions placed by the Trust on its cardiac services, beyond the detailed analysis contained within the Trust's PFD response, to which we again defer.

vii. The "apparently unfounded damage to the reputation of the cardiac surgery department" that will take years to repair; increasing risk of future deaths by damaging public confidence in the Trust and the NHS

It is not clear whether this concern is directed at the Review, or more generally at the sequence of events over a period of years of concerns, investigations and public scrutiny of the Trust's cardiac services. If this relates to the impact of the Review, our earlier comment on the timeline refers. It is clear that any such damage had already occurred before NHS Improvement commissioned the Review or any opinions were expressed in the SJRs.

The Trust's PFD response addresses the detail of referral patterns over the relevant period. NHSE and the Trust have been working to re-establish public confidence in cardiac care in South London, and the evolution of the Cardiac Collaborative reflects that.

viii. Restrictions on training, collapse of research and staff leaving, further damages not only cardiac surgery at the Trust but also wider cardiac surgery field, increasing the risk of death to patients by reducing their access to high quality care

It is stated in the PFD report that training has been severely constricted. For the avoidance of doubt, we understand from the Trust that the decision to remove trainees from St George's cardiac surgery service was taken by Health Education England (HEE) on 11 September 2018 before the Review was commenced. The Trust's PFD response provides further detail on HEE reasoning for their decision, and the subsequent reviews that they have undertaken, and data regarding the relative stability of staff numbers. These are not matters arising from the Review. The Trust's response also evidences the mitigation in place to support continued high quality care despite the removal of trainees. In addition, the South London cardiac surgery network ensures appropriate access to high quality care for patients in need of that care.

ix. Restrictions at STG may make surgeons more risk averse and complex patients will be denied care, increasing risk of death

We defer to the Trust's response on this concern.

x. The SJR process was not fit for purpose, undermining public confidence in the NHS which the public may perceive as being unable to appropriately audit its own work.

For the reasons set out above, we consider the Review was fit for purpose. The Review explored just over 200 cases where patients had died following surgery, and identified a number of aspects of good care, as well as identifying some concerns regarding decision making, documentation and pre and post-operative care for some of the patient deaths reviewed. We accept that you, as HM Senior Coroner, have arrived at different findings in cases reviewed through the separate statutory process of an inquest. It is our view that this does not invalidate the collective opinion of a panel of clinical experts conducting a desktop review. A range of opinions is not unexpected in complex clinical matters. We also note that the concerns in one SJR have already been repeated at inquest.

The purpose of the Review was to inform the response to NICOR alerts and concerns regarding the dysfunctional relationships in the service, and the concern that this may be having an impact on decision making and team working for patient care. It has to be remembered that the "NHS does not stop" and the SJRs were being conducted to understand what issues if any caused the unit to be a mortality outlier while the unit was still operational (albeit under restrictions) and to inform any changes necessary. It is therefore not unreasonable that they were conducted to a tight timescale, particularly as this process is used to make safety and quality judgements. We can therefore anticipate that any such panel, would, whilst doing their professional best, need to form conclusions efficiently, and 'call out' deficiencies when identified, as they have done with the SJR process.

Concluding comments:

We regret that the PFD in this case could potentially set back the approach to restoring service capacity and relationships at the Trust, as well as public confidence, creating further conflict and doubt for families, staff and leadership teams in both the Trust and NHSE, at a time when the focus is (rightly) on restoration of relationships and quality of the service, in the sole interest of patient safety.

We hope that this detailed response from NHSE's perspective as commissioners, and indeed the assurance provided by the Trust's response as a provider of care, assists both you as Senior Coroner, but also the families involved in inquests that have been reopened following notification to you of the findings of the Review. We hope, in particular, that there is better understanding of the purpose of the Review when it was commissioned, and how in our view it is necessarily different, both in terms of methodology and, it appears, outcome, to an inquest you conduct under your statutory powers.

It is our sincere hope that future clinical experts contributing to service reviews are not discouraged from participating in such exercises as a result of the criticism the Review and an individual (the Chair) has received at inquest, both in court and in the PFD. We see such reviews as a key component in the wider architecture of investigating and improving patient safety in this country. In our view the Review provided useful recommendations which have contributed to the strategic approach to cardiac services at the Trust and within South London and has contributed to a process of continuous improvement in the interest of patient safety.

Yours sincerely

National Medical Director
NHS England