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National Medical Director
NHS England
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05 August 2022

Dear Mr Broadbridge

Re: Regulation 28 Report to Prevent Future Deaths – Rita Britten who died on 29 July 2018.

Thank you for your Report to Prevent Future Deaths (hereafter “Report”) dated 13 May 2022 concerning the death of Rita Britten on 29 July 2018. I would like to express my deep condolences to Rita’s family.

I note the inquest concluded Rita’s death was a direct result of a choking incident on 26 July 2018.

Following the inquest, you raised concerns in your Report that there should be clear national emergency/resuscitation guidelines for dealing effectively with choking incidents where the individual is overweight/obese or otherwise where “conventional abdominal thrusts” are not possible or are less able to be effectively applied. You stated that there should be early review and assessment of papers that discuss the efficacy in such circumstances of “inversion” of the affected choking individual and how this or similar techniques might have application in the hospital/clinical setting in which this choking episode occurred. You have added that there should be specialist equipment to assist in these circumstances.

I note that you also sent your Report to the Resuscitation Council UK and I have had sight of their response. I am assured that Resuscitation Council UK have addressed all the concerns raised in your Report.

Although the circumstances surrounding this case are not specifically within NHS England’s sphere of statutory responsibility, I have brought the matters of concern to the attention of colleagues across our National Patient Safety Team (NPST) to support any general work around safety and quality of care in this area.

I would also like to provide further assurances on national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by a 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 preventable deaths 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