National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

15 March 2023

Crispin Oliver
Assistant Coroner
County Durham and Darlington Coroner's Court
P.O. Box 282
Bishop Auckland
Co. Durham
DL14 4FY

Dear Mr Oliver

Re: Regulation 28 Report to Prevent Future Deaths – Joseph Andrew Price (Andrew), D.O.B 05 December 1991.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 19 January 2023 concerning the death of Andrew Price on 20 September 2020 at HMP Durham. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Andrew's family and loved ones. NHS England is keen to assure the family and the Coroner that the concerns raised about Andrew's care have been listened to and reflected upon.

Following the inquest, you raised concerns in your Report regarding:

1. Lack of a specific question relating to family history of sudden cardiac death in the reception health and secondary health screen templates.

2. Lack of an appropriate way of recording family history of sudden cardiac death within the SystmOne template, and lack of an appropriate 'read code' for this meaning staff are not easily able to identify when this information is recorded.

It should be noted that the UK National Screening committee does not recommend that screening is undertaken for younger individuals, namely those aged 12-39 years, as there is not enough evidence to support the screening. This is because:

- There is uncertainty about how many young people each year are affected by sudden cardiac death.
- It is unclear whether the tests could accurately detect heart conditions in young people not displaying any symptom.
- There is no research evidence that testing young people has reduced or is likely to reduce the chance of a sudden cardiac death.

More information regarding the research undertaken by the UK National Screening Committee can be found at Sudden cardiac death - UK National Screening Committee (UK NSC) - GOV.UK (view-health-screening-recommendations.service.gov.uk).

Andrew was 28 years old at the time of his death meaning he fell within the age range for which screening is not recommended.

With regard to your concern regarding the lack of a specific question relating to family history of sudden cardiac death in the reception health and secondary health screen templates, I understand that as an immediate response to your report, the prison healthcare provider responsible for ten prisons across the North East and Yorkshire region (including HMP Durham), has added an additional question to the secondary screening templates relating to family history of sudden cardiac death.

At a national level, the second health assessment, which should be undertaken within seven days of the reception screen and should act as a prompt to ask relevant questions relating to family history, is carried out in line with guidelines from the National Institute for Health and Care Excellence (NICE). It includes a question specifically relating to any history of serious illness in the person's family, for example heart disease.

These guidelines also point out the need to have a system and processes in place to carry out other assessment and highlight action to take in terms of referring a person to a General Practitioner (GP) or relevant clinic if further assessment is needed, for example upon identification of cardiovascular disease. More information can be found at Recommendations | Physical health of people in prison | Guidance | NICE

In relation to your concern raised over a lack of appropriate read code for sudden cardiac death, there is no specific read code for sudden death syndrome on any clinical system, which is likely due to the fact there is no evidence to screen for it. NHS England is however refreshing the secondary health screening template to include a specific prompt for users to ask relevant questions relating to family history.

I would 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 Andrew 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,

[redacted]

National Medical Director
NHS England