National Medical Director
NHS England
Wellington House
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Ms Abigail Combes
On behalf of:
County of West Yorkshire (Eastern District)
Coroner's Office and Court
71 Northgate
Wakefield
WF1 3BS

[redacted]

[redacted]

25 April 2023

Dear Ms Combes,

Re: Regulation 28 Report to Prevent Future Deaths – David John Nash who died on 4 November 2020.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated Tuesday 31 January 2023, concerning the death of David John Nash on 4 November 2020. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to David's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about David's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused to David's family or friends. I realise that responses to Coroner Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones and appreciate this will have been an incredibly difficult time for them.

Your Report raised the following concerns over how complaints made about the primary care service provided to David were handled:

1. **That the complaint was handled without a clinical rationale from the GP Practice being provided which resulted in the clinical reviewer revising their opinion once that information was provided in the anticipation of inquest proceedings.**

   A review of our records indicates that when the review was undertaken it included the clinical rationale from the GP Practice. As part of their clinical review, the clinical reviewer requested further information from the practice which included specific records and transcripts. This was provided and the clinical review was completed.

   In response to a request from the complainant seeking further clarification on comments attributed to the clinical reviewer in the complaint response, a further clinical review was provided. Whilst this provided further clarification in relation to comments made, it did not represent a change in clinical view.

2. **That the GP Practice was not made aware of the concerns raised by the clinical reviewer until the inquest process had disclosed these concerns. You raised that it was unclear how the NHS England Primary Care Complaints Team ensured that their clinical reviews are fully informed and**

how information is shared back to a service/Practice to ensure appropriate learning can be taken.

Our review has shown it appears that copies of the complaint responses were not shared with the GP practice. NHS England apologises for this and for any distress caused to the family. NHS England updated its complaints policy in October 2021, to state that all responses must be shared with the provider and this change should have been acknowledged and acted upon. We will ensure all regions are reminded of the complaints policy and the need to be compliant with the policy.

3. **That it was not clear on the general process for cascading information to a Primary Care Network where it is appropriate to raise awareness of an issue or condition.**

It is not NHS England policy to routinely share information with Primary Care Networks, however, agreed ways of working and processes are in place to ensure sharing and learning from complaints.

Regionally, this is carried out through the quality processes in locality teams and Integrated Care Boards (ICBs) to ensure that any learning is shared, and that GP Practices are appropriately supported.

Nationally, cascading of information and the dissemination of learning is implemented through something called the National Learning Report. NHS England will include a reference to your Report to Prevent Future Deaths in the next National Learning Report and ensure the learning around the handling of complaints is included.

Regarding the above, NHS England will be taking the following actions to address the concerns raised in your Report:

1. NHS England will ensure that all regional complaints teams are reminded of the requirement to share a copy of its final response with the provider(s) concerned, in line with NHS England policy.
2. NHSE can confirm that we will include a reference to your Report and the concerns raised in the next National Learning Report and ensure the learning around the handling of complaints is included.
3. NHS England will remind all regional complaints teams that it is good practice to liaise with a coroner when an inquest is running parallel to a complaint.

I would also like to provide further assurances on national NHSE 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 preventable deaths are shared across the NHS at both a national and regional level and helps us 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]

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National Medical Director