NHS England

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Manchester South Coroner's Court
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National Medical Director
NHS England
Wellington House
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[redacted] [redacted]

09 August 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Raymond Lee who died on 14 September 2021.

Thank you for your report to Prevent Future Deaths (hereafter "Report") dated 15 May 2023 concerning the death of Raymond Lee on 14 September 2021. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Raymond's family and loved ones. NHS England is keen to assure you that the concerns raised about Raymond's care have been listened to and reflected upon appropriately.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused. We realise our response may form part of the important process of family and friends coming to terms with what has happened to their loved one and appreciate this will have been an incredibly difficult time for them.

As you note in your Report, evidence given at the inquest highlighted the recognised risks and complications related to radiotherapy for oesophageal cancers, notably strictures and perforations.

To support a response, I sought the opinion from our clinical advisor within the Cancer Programme of Care at NHS England and they have also spoken to the relevant professional association lead from the Association of Upper Gastrointestinal Surgery of Great Britain and Ireland (AUGIS). In terms of learning from this case, and from other stenting cases previously reviewed, it is clear that these types of cases are clinically difficult to manage; the NICE guidance is not comprehensive and there does not appear to be a guidelines in place covering these sorts of circumstances (i.e., post radiotherapy). We acknowledge this is something that needs to be addressed and we are actively discussing how best to do this in partnership with AUGIS and NICE. We agree that national, evidence-based advice / guideline would be of benefit to clinicians and patients, and we will work together to develop this in an appropriate way.

I have also received an update from Greater Manchester Integrated Care Board (ICB) regarding this matter. They have advised that the Greater Manchester (GM) Cancer Alliance will be tasking the Oesophago-Gastric (OG) Pathway Board with developing a clear pathway for the management of oesophageal stenting. The Alliance will also be ensuring that outstanding elements of the Multi-Disciplinary Team (MDT) Reform

Programme are actioned within the Cancer Alliance's programme of work for 2023/24. The ICB has provided NHS England with assurances that they will be following up with GM Cancer Alliance on these actions.

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 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 this 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,

National Medical Director