NHS England

Alison Mutch
Senior Coroner
Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

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

[redacted]

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10 October 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Jane Elizabeth Wadsworth who died on 31 December 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 17 July 2023 concerning the death of Jane Wadsworth on 31 December 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Jane's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Jane'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 Jane'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.

The matters of concern raised in your Report come under the remit of Tameside and Glossop Integrated Care NHS Foundation Trust (hereafter "the Trust"), who are therefore the appropriate organisation to respond to the concerns raised. I am however grateful to you for bringing these important patient safety issues to my attention. The concerns have been shared with my relevant regional Quality colleagues in the North West, who are engaging with Greater Manchester Integrated Care Board (the responsible commissioning body for Greater Manchester) about the issues raised.

NHS England had been waiting to be sighted on the Trust's response to you, which we received a copy of on 2nd October 2023. We note that the Trust's response does address each of the concerns raised in your Report and that they have been implementing improvement work to address missed doses of medication, together with new processes for clinical documentation and review.

Your Report will also be 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 again for bringing these issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]
National Medical Director