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

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

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22 December 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Kirsty Michelle Hendry who died on 11 April 2023

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 20 October 2023 concerning the death of Kirsty Michelle Hendry on 11 April 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Kirsty's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Kirsty'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 Kirsty'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.

In your Report you raised the concern over the awareness of the symptoms of a burst aneurysm within primary care health settings. Senior colleagues from NHS England's Primary Care, Nursing and Neurology Teams were therefore asked to review your Report and have input into this response.

All healthcare professionals, including those within Primary Care, have access to and should be guided by National Institute for Health and Care Excellence (NICE) clinical guidance. In November 2022, NICE published clinical guidance NG228 on Subarachnoid haemorrhage caused by a ruptured aneurysm: diagnosis and management. The clinical guidance provides information on the diagnosis and management of aneurysm and highlights the importance of urgent investigation and the need to have a 'high index of suspicion' for subarachnoid haemorrhage in people who present with unexplained acute severe headache. If there is a suspicion of subarachnoid haemorrhage in people being seen outside of acute hospital settings, the guidance is to refer them to an emergency department immediately for further assessment.

Separate NICE clinical guidance, CG150, Headaches in over 12s: diagnosis and management also makes clear the need for urgent assessment of sudden severe headaches.

As part of their appraisal and validation, all healthcare professionals working within Primary Care will undertake Continuing Personal Development (CPD) to keep their clinical skills up to date. This will include ensuring awareness of up-to-date clinical guidance.

My nursing colleagues for Primary Care will also be considering Kirsty's case further, to include raising awareness of brain aneurysm symptoms among primary care nursing professionals. They will be keeping my team updated on their agreed next steps.

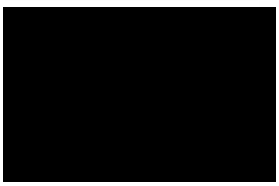
NHS England has also engaged with Tameside and Glossop Integrated Care NHS Foundation Trust regarding your Report and the circumstances surrounding Kirsty's care. At the time, there were delays within the Emergency Department to patients being seen and assessed by doctors. A programme of work is underway both locally and nationally to address waiting times and delays within Urgent Emergency Care (UEC). For more information on this, please see the Delivery plan for recovering urgent and emergency care services which NHS England published in January 2023. The plan includes an ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024.

Following Kirsty's death, the Trust has developed an action plan which includes further education for staff on the completion and escalation of neurological observations. They have also advised that they have acted around the erroneous reporting of Kirsty's CT scan, with the third-party provider now having to provide quarterly reports to the Trust, incorporating a peer review audit. I would refer you to the Trust for further information on their action plan.

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 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,



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National Medical Director