Carly Elizabeth Henley
Assistant Coroner
Newcastle upon Tyne and North Tyneside
Lord Mayor's Suite
Civic Centre
Barras Bridge
Newcastle upon Tyne
NE1 8QH

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

[redacted]

19 December 2023

[redacted]

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Tyler Jay Ryan who died on 12 February 2021.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 17 October 2023 concerning the death of Tyler Jay Ryan on 12 February 2021. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Tyler's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Tyler'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 Tyler'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 raise a concern over the shortage of Paediatric Pathologists and the delays that this can cause to Paediatric Pathology reports. The shortage of paediatric and perinatal pathologists and the impact it has on services has been of concern for some time. This issue has been the subject of a great deal of activity relating to attracting pathologists into higher specialist training in this area with the implementation of recruitment incentives (one-off payments of £20,000) as well as supporting learning via e-learning resources. Work is also ongoing with NHS England's Children and Young People's Team, the Pathology Team and the Workforce Training and Education Directorate, as well as professional bodies such as the Royal College of Pathologists (RCPath) and the Institute of Biomedical Science (IBMS) to develop a curriculum for placental pathology reporting for biomedical scientist advance practice to supplement the stretched workforce. There isn't a timeline for this at the moment but we are happy to update the coroner once further progress has been made.

Guidance on autopsy in children is issued by the RCPath and will cover the need for genetic analysis where indicated. I note that you have also issued your Report to the

RCPath and they would be the appropriate organisation to provide comment on your concerns touching on molecular autopsy.

In your Report you also reference the Kennedy Guidance and the need for a revision of the Sudden Unexpected Death In Children (SUDIC) protocol. The guidance was published in November 2016 and was developed by the RCPath in collaboration with the Royal College of Paediatrics and Child Health (RCPCH). NHS England will be raising the issue of the revision with the Royal Colleges and the relevant government departments.

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,

[redacted]
National Medical Director