NHS England

Deborah Rachel Lakin
Assistant Coroner Coventry & Warwickshire
Warwickshire Justice Centre
Newbold Terrace
Leamington Spa
CV32 4EL

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

23 February 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Andrew Douglas Guillaume who died on 20 June 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 29 December 2023 concerning the death of Andrew Douglas Guillaume on 29 December 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Andrew's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Andrew's care have been listened to and reflected upon.

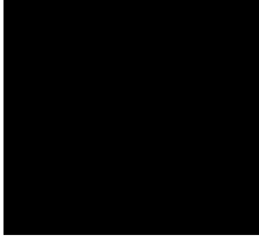
The matters of concern raised in your Report predominantly fall under the remit of the relevant Trusts, South Warwickshire University NHS Foundation Trust (SWFT) and University Hospitals Coventry and Warwickshire NHS Trust (UHCW). I note that you have addressed your Report to SWFT, but you may also wish to address your concerns to UHCW.

NHS England has already been sighted on SWFT's Root Cause Analysis Investigation Report, which we understand has been shared with the coroner and Andrew's family. We note that lessons have been learned around communication, documentation and the problems encountered by SWFT in contacting UHCW. We welcome the report's action plan which, in addition to the joint review references above, includes a review of UHCW referral mechanisms and circulation of a Trust-wide Safety Practice Alert with the priority telephone number for UHCW referrals. NHS England has also asked to be sighted on the Trust's response to your Regulation 28 report so that we can, in addition, give it due consideration.

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,



National Medical Director