

Mr David Manknell KC
HM Assistant Coroner
Inner South London Coroner Area
Southwark Coroner's Court
1 Tennis Street
London
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National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
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05/08/2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Joshua Arthur Stafford Delaney who died on 19 January 2020.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 8 April 2024 concerning the death of Joshua Arthur Stafford Delaney on 19 January 2020. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Joshua's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Joshua'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 Joshua'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.

Your Report raises the concern that doctors in General Practice may not be aware of the risks of fatal overdose from Propranolol, and that in the absence of greater awareness by GPs, the prescription of quantities of Propranolol to those at risk may cause future deaths.

The National Institute for Health and Care Excellence (NICE) [guidance](#) on generalised anxiety disorder and panic disorder in adults (published on 26 January 2011) does not recommend the use of Propranolol in anxiety and there is no recommendation in the British National Formulary (BNF), which provides key information for prescribers on the selection, prescribing, dispensing and administration of medicines, to use Propranolol for the treatment of anxiety in isolation. The BNF does however provide [dose information](#) for Propranolol for the treatment of anxiety symptoms such as palpitation, sweating and tremor, reflecting the licensed dose for these indications and including information on the risk of overdose from Propranolol. Under the 'important safety information' section, there is also reference to the Health Services Safety Investigations Body ([HSSIB](#)) [patient safety investigation](#) from February 2020, regarding the potential under-recognised risk of harm from the use of Propranolol.

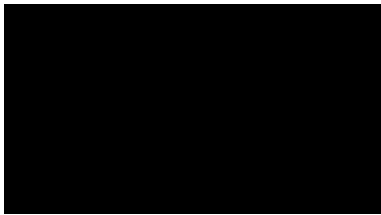
My colleagues from NHS England's National Patient Safety Team have been engaging with NICE to flag the circumstances of Joshua's death and inviting them to strengthen their cautions around the use of Propranolol.

Following our review of this case, it has also been agreed that NHS England will issue communications to GPs to reiterate that NICE do not recommend Propranolol as a treatment option for anxiety, and emphasising the risks involved in its administration, and we will do so as soon as practicable. NHS England are also engaging with the Medicines & Healthcare Products Regulatory Agency (MHRA), who we understand are also considering some communications on this issue. NHS England are happy to update the Coroner in due course and once communications have been issued.

I would also like to provide further assurances on the 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 events, such as the sad death of Joshua, are shared across the NHS at both a national and regional level and helps us to 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 name]

National Medical Director