National Medical Director
NHS England
Wellington House
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London
SE1 8UG

[redacted]

25 March 2024

David Donald William Reid
HM Senior Coroner
Worcestershire Coroner's Court
The Civic, Martins Way
Stourport-on-Severn
Worcestershire
DY13 8UN

[redacted]

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Michael Leslie Pegg who died on 15 January 2023

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 26 January 2024 concerning the death of Michael Leslie Pegg on 15 January 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Michael's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Michael's care have been listened to and reflected upon.

In your report you raised concerns that those treating Michael failed to follow National Institute for Health and Care Excellence (NICE) guidelines relating to the treatment of those with adrenal insufficiency conditions who are being treated for intercurrent illness. NICE are responsible for producing these clinical guidelines and NHS Trusts and bodies are expected to pay due regard to NICE and Royal College guidelines. As you note in your Report, there is existing guidance on this issue from NICE. They are also due to publish updated guidance on Adrenal insufficiency: acute and long-term management later this year.

NHS England has also worked closely with the Society for Endocrinology and the Royal College of Physicians on the issue of under-recognition and treatment of adrenal insufficiency or crisis. This culminated in the publication of 'Guidance for the prevention and emergency management of adult patients with adrenal insufficiency' in July 2020, which outlines the causes of adrenal insufficiency, groups at risk of an adrenal crisis, emergency management and management for surgical procedures. As a result of work in this area, a new NHS Steroid Emergency Card was developed, to be carried by patients at risk of adrenal crisis and ensure the prompt delivery of steroids to those patients presenting within an emergency or acute medicine setting.

The work above also resulted in the publication of the National Patient Safety Alert (NatPSA), which includes the specific action that '*Providers that treat patients with acute physical illness or trauma, or who may require emergency or elective surgical or other invasive procedures, including day patients, should review their admission/assessment/examination/clerking documentation to ensure it includes prompts to check for risk of adrenal crisis and to establish if the patient has a Steroid Emergency Card*.' Trusts were expected to implement actions around this specific alert by 13 May 2021 and Worcestershire Acute Hospitals NHS Trust is recorded as being compliant with this. We also note that it appears that the Trust has an internal guideline on the management of adrenal insufficiency, published in March 2022. The Royal College of Emergency Medicine (RCEM) has also issued professional guidance on Addisonian Crisis.

Your Report also raised the concern that Michael received treatment in the Resus Corridor and in the Major's Overflow area and that the noisy and crowded conditions put proper treatment of patients at risk. NHS England recognises that services across the NHS are currently facing significant pressures. NHS England is committed to improving patient experience within hospitals and in January 2023 we published a two-year Delivery plan for recovering urgent and emergency care services. The plan aims to relieve pressures on emergency departments by:

- Growing the workforce available for 111 online and urgent call services to offer support, advice, diagnosis and referral.
- Expanding services within the community to prevent avoidable A&E admission. This will include more joined-up urgent care within the community and use of virtual wards.
- Helping people access the right care first time, ensuring that 111 is the first port of call and reducing the need for people needing to go to A&E.
- Growing capacity and number of beds within hospitals to relieve pressures on A&E Departments.

NHS England would refer you to the Trust on what actions are being taken locally to address your concerns. We have been sighted on their Serious Investigation Report and Action Plan and note that they have taken learnings around Emergency Department crowding and improving end-of-life care for patients and are reviewing staffing levels in the Overflow Area and Acuity.

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