Ms Sonia Hayes
Area Coroner
Essex and Thurrock Coroner's Service
Essex County Council
Seax House
Victoria Road South
Chelmsford
CM1 1QH

[redacted]

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

[redacted]

9 September 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Chloe Hunt who died on 15 March 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 19 June 2024 concerning the death of Chloe Hunt on 15 March 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Chloe's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Chloe'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 Chloe'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 concerns with the care provided to Chloe whilst she was a patient at Colchester General Hospital. It is appropriate that East Suffolk & North Essex NHS Foundation Trust respond to your concerns, which do not fall under NHS England's remit.

I would, however, like to provide assurance that my senior regional colleagues in the East of England are aware of your Report and have been engaging with the Trust on the concerns raised.

NHS England has been sighted on the Trust's response to the Coroner dated 12 August 2024, and we note that learnings have been taken from Chloe's care and presented at their Governance meetings, Morbidity and Mortality Review meetings and daily ward huddles. We also note that they are taking actions to ensure there will always be a member of staff on shift with Immediate Life Support training. I refer the Coroner to the Trust's full response for further information.

I would 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 Chloe, 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,

National Medical Director