Ms Anna Loxton
HM Assistant Coroner for Surrey
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[redacted]

National Director of Patient Safety
NHS England
Wellington House
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[redacted]

6 November 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Jeffrey Marshall who died on 13 December 2023

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 13 August 2024 concerning the death of Jeffrey Marshall on 13 December 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Jeffrey's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Jeffrey's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to respond to your Report, and I apologise for any anguish this delay may have caused to Jeffrey'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 raised the concern that there is no national guidance to assist clinicians in determining when anticoagulation should be recommenced following a traumatic head injury, nor any recommendation for clinicians to discuss the risks and benefits of withholding anticoagulation with their patients.

I note, in addition to NHS England, that your Report has been addressed to the National Institute for Health and Care Excellence (NICE). They are the appropriate organisation to respond to the Coroner's concerns, as the provider of the relevant clinical guidance. NHS England will carefully review NICE's response to the Coroner in due course, and consider whether any resultant actions are required from us.

It should however be noted that there will need to be a significant degree of individualised care and decision-making in cases such as Jeffrey's. There will need to be careful consideration of the risks of atrial fibrillation stroke versus the risk of precipitating bleeding (dependent on different patient factors), and that this could provide challenge to producing specific guidance on this issue.

It is difficult for NHS England to provide more detailed comments on the quality of care delivered to Jeffrey based on the information in your Report. However, we do note that there looks to have been a significant delay between the second CT scan being taken

on 8 November 2023 and the results being reported on 3 December 2023, and that it is possible this could have delayed any decisions on whether to restart Jeffrey's anticoagulation medication. My colleagues in the South East region have been asked to gather further information on this, as part of our Regulation 28 assurance processes.

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 events, such as the sad death of Jeffrey, 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,

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National Director of Patient Safety