NHS England

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[redacted]

19 December 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Kasey Beech who died on 13 October 2021.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 29 August 2024 concerning the death of Kasey Beech on 13 October 2021. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Kasey's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Kasey'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 to Kasey's family or friends. I realise that responses to Coroner's Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones, and I appreciate this will have been an incredibly difficult time for them.

The matters of concern as presented in your Report include the use of the STREAMing model / guidance to assess and exclude a cardiac cause of chest pain in new non-injury ambulatory patients. In particular, you raised that the prioritisation of current cardiac sounding chest pain and the streaming to the Medway on Call Care (MedOCC) or an equivalent service may be to the detriment of other patients who are nonetheless at risk of sudden deterioration, creating a risk of future deaths in both cardiac and non-cardiac patients.

NHS England have engaged with colleagues at Medway Maritime Hospital to understand how the STREAMing model upon which their Urgent Treatment Centre (UTC) operates and I can confirm that NHS England does not endorse a particular STREAMing model nationally.

The training and experience of the initial assessor at an UTC is critical to patient safety and the Royal College of Nursing (RCN) and the Faculty of Emergency Nursing (FEN) have specific training and competencies for clinical staff working in initial assessment roles.

Models of initial assessment currently in use prioritise a patient with chest pain as an acuity 2 patient who should be seen urgently, with a general aim (based on international consensus) that this should be within 10 minutes.

NHS England is currently developing a new initial assessment model in collaboration with the Royal College of Emergency Medicine (RCEM), the RCN, the FEN, the Emergency Nurse Consultant Group, and lay (patient) representation. This new model has been successfully introduced in more than 20 sites across England and is specifically focused on improving patient safety. This new model has been successful in bringing down the time to initial assessment to below 15 minutes in sites where it has been implemented.

The Emergency Care Data Set, introduced in 2017, discouraged the concepts of 'cardiac chest pain' and 'non-cardiac chest pain' for the reasons identified in your Report. Instead, all chest pain was coded solely as 'chest pain'.

In response to your specific concerns relating to the care of Kasey, I have consulted with NHS England's National Clinical Director for Heart Disease. They advise that it is recognised that pain can often fluctuate over time but that the lack of ongoing pain in someone with other features suggesting a low risk profile is clinically reassuring, and the streaming / direction of Kasey to the MedOCC was appropriate in the circumstances.

As noted in your Report, pain can also be masked by analgesia, especially if intravenous or intramuscular opiates have been administered prior to assessment. This is a key reason why other features such as the general condition of the patient and any breathlessness must be assessed. These assessments are included in the STREAMing pathway.

Following their review, I am advised by the National Clinical Director that the STREAMing pathway in use by Medway Maritime Hospital does not have an undue prioritisation of chest pain (particularly cardiac-sounding chest pain). As indicated above, the general condition of the patient, any signs of breathlessness, their ability to talk in sentences and their ability to walk unaided are all assessed. In this tragic case, the initial assessments all pointed towards a low-risk situation for which direction to the MedOCC was appropriate. A low risk initial assessment does not completely rule out the possibility of future deterioration but usually indicates the lack of a need for immediate treatment.

In this case, Kasey deteriorated rapidly after leaving the MedOCC. It does not appear that modification of the STREAMing pathway would have been likely to have predicted that or altered the outcome of the initial assessment.

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

Kasey, 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]
National Medical Director