Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

[redacted]

National Director of Patient Safety
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

25 November 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Chamali Bibi who died on 4 March 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 9 October 2024 concerning the death of Chamali Bibi on 4 March 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Chamali's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Chamali's care have been listened to and reflected upon.

Your Report raises the concern that periacetabular osteotomy (PAO) procedures may not be being carried out by suitably experienced practitioners and that Trusts may not recognise it as being a specialist procedure, as opposed to a surgical technique. My response to the Coroner has been informed by specialist orthopaedic clinical opinion.

The Coroner is correct in their assertion that PAOs are a specialist procedure which should be undertaken only by clinicians with the requisite training and experience, who perform the procedure regularly. Clinicians should keep a record of their procedures and their outcomes, and it should form part of their annual appraisal and reaccreditation processes. Surgeons who have not undertaken the required training and fellowships should not perform PAO procedures. It is NHS England's opinion that Orthopaedic Surgeons will already be aware that a PAO is a specialist procedure, and that Trusts should therefore be aware of this too.

It is not appropriate for NHS England to provide further comment on the concerns raised in your Report, based on the information provided. I understand from your Report that you are satisfied that Barts Health NHS Trust have addressed several matters which you felt required further attention, and undertakings were given to you in court in this respect. Your Report has also been sent to my regional colleagues in London as part of our internal Regulation 28 assurance processes. It is not therefore appropriate for NHS England to provide further comment on these specific concerns.

NHS England are not the responsible organisation for the relevant clinical and professional standards and guidance raised in this matter. The Coroner may wish to refer to the Royal College of Surgeons (RCS) of England or the British Orthopaedic Association (BOA) if they feel they require further information.

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 Chamali 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 Director of Patient Safety