NHS England

Dr Karen Henderson
Assistant Coroner
HM Coroner's Court,
Station Approach,
Woking
GU22 7AP

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
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09 December 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Mia Louise Gauci-Lamport who died on 11 September 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 14 October 2024 concerning the death of Mia Louise Gauci-Lamport on 11 September 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mia's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Mia's care have been listened to and reflected upon.

Your Report raises multiple concerns in relation to the medical care and appropriate monitoring of Mia, including concerns regarding the access to clinical consultant care and a lack of adherence to her care plan within the residential care setting at Tadworth Children's Trust (TCT). Noting you have also sent your Report to TCT and CQC, some of the concerns you raise may be better addressed by those organisations. In this response, I have addressed the matters of concern where NHS England are able to contribute and provide some assurance.

My response to your Report has been informed by colleagues in the South East Region Direct Specialised Commissioning Quality team who commission 12 beds from Tadworth Children's Trust (TCT) on behalf of NHS England for specialised rehabilitation for patients with complex needs. However, I should like to clarify that Tadworth Children's Trust is also commissioned for other levels of rehabilitation and residential care funded by Integrated Care Boards (ICBs) and local authorities. TCT have a total provision for up to 50 children. Whilst you have drawn our attention to previous concerns you have raised about TCT in an PFD report following the death of Connor Wellsted, TCT have confirmed that Mia was within its residential care provision commissioned by the local authority and was not in a specialised commissioning bed for which NHS England would have had oversight.

Even though NHS England had no direct or commissioning oversight of Mia's care, I should like to provide you and Mia's family with some assurance that our regional Specialised Commissioning team has been working with TCT, alongside other stakeholders, to review the quality of care being provided. This has taken the form of Rapid Quality Review (RQR) meetings in accordance with the National Quality Boards guidance on risk response and escalation in ICSs where concerns are raised about a

provider. This multi-stakeholder meeting gives specific, focused consideration to quality concerns or risks raised, helps to facilitate rapid diagnostic work and looks to formulate an agreed action and improvement plan with the provider. Such meetings bring together regional safeguarding, quality, local authority, acute trust, CQC and clinical and governance teams.

A recent RQR meeting with TCT has resulted in an agreed plan for them to adopt the national paediatric early warning system (PEWS). This is a standardised approach for tracking the deterioration of children used in hospital settings. The acute trust paediatric nursing colleagues involved in the RQR meeting were positive about the steps TCT had taken so far to review and audit observations and monitoring. In addition, the nursing colleagues have offered to support TCT with training and education of staff and to act as a critical friend to improve nursing and carer practice on appropriate observation and monitoring. The PEWS system also has standardised charts for recording clinical information and observations which will also help improve consistency of medical record keeping at TCT.

In terms of multi-disciplinary and collaborative care provision, at the RQR meeting, it was agreed that TCT would ensure children were only accepted when the correct care had been commissioned and that the right level of care could be safely provided.

Whilst a RQR meeting helps support and implement plans for a provider following identification of a risk or concern, it also gives the provider a platform to raise concerns or challenges they have in being able to deliver that care. At the RQR meeting with TCT, it was acknowledged that they not been able to consistently engage with NHS partners to support their care pathways for each child in their care. Although the clinical teams at TCT have worked hard to form connections with primary care and clinical teams within the NHS, it is acknowledged that agreed pathways are not always easy to progress with those teams. To help bridge that relationship and ensure better consistency of collaborative care, TCT agreed to further their connections within the local integrated care system and with tertiary care providers to improve flow to clinical appointments. Our NHS England Regional Medical Director has also offered to support with connecting TCT's clinical team to specialists within the NHS that can offer peer support and further improvement work. However, it would remain TCT's responsibility to ensure consistency of multi-disciplinary clinical support for all children in their care, whether accessed via NHS or privately funded.

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 Mia, 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