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National Medical Director
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10 January 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Lisa Gale who died on 5 April 2023

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 12 November 2024 concerning the death of Lisa Gale on 5 April 2023, addressed to NHS England's Chief Midwife. I am responding on behalf of the organisation in my capacity as National Medical Director but would like to assure you that NHS England's Chief Midwifery Officer has also reviewed your Report and been sighted on this response.

In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Lisa's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Lisa's care have been listened to and reflected upon.

Your Report raised concerns over the Royal College of Pathologists' guidelines for urgent reporting of liver function tests (LFTs) undertaken on pregnant women, despite pregnancy specific conditions such as Acute Fatty Liver of Pregnancy (AFLP) being potentially fatal at much lower levels of abnormal LFTs. Specialist Maternity, Obstetrics & Midwifery colleagues at NHS England have been consulted on my response to the Coroner.

NHS England has led the establishment of Maternal Medicine Networks (MMNs) across England, so that all women can receive specialist advice and care for the management of chronic and acute medical problems before, during and after pregnancy. All 14 Networks have been operational for two years as of December 2024.

The National Service Specification for Maternal Medicine Networks, published in October 2021, describes the care pathways and clinical dependencies of MMNs and maternal medicine centres (MMCs). Every Network is responsible for agreeing shared protocols on the management and escalation of medical problems that pre-exist or arise in pregnancy and in the puerperium (6 week postpartum period). Every Network has at least one MMC, which provides advice or care for the highest risk cases, along with advice, training and education for local units across the Network. Where specialist advice or care has been provided at an MMC, this will continue for as long as deemed medically necessary.

Diagnosis of rare conditions such as acute fatty liver of pregnancy can be challenging due to the differences in physiology for pregnant and non-pregnant women. Whilst maternal medicine networks would be expected to drive up the quality of care for women with acute medical conditions in pregnancy, such as acute fatty liver, and raise awareness around presentation, the problem identified was a delay in diagnosis owing to an abnormal result in a pregnant woman not being recognised as such and so not urgently reported. NHS England would therefore support the revision of the Royal College of Pathologists' guidelines to incorporate different urgent reporting levels for results of tests taken during pregnancy, and we note that the Coroner has also addressed your Report to the College.

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 Lisa, 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