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National Medical Director
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17 March 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – David Christopher Peter Lodge who died on 13 January 2022

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 23 December 2024 concerning the death of David Christopher Peter Lodge on 13 January 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to David's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about David'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 David's family or friends. I realise that responses to Coroners' 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.

Your Report raised concerns that no reasonable adjustments were made at the Emergency Department (ED) David was being treated at to assess David's pain, given that he was not able to communicate verbally with medical professionals, that basic examinations were not carried out, and that NEWS2 scores above seven were not being appropriately escalated.

In response to the specific questions of the Coroner, NHS England was not involved directly in providing clinical care to David and therefore does not have access to the clinical records of the Trust where he was admitted. On account of this, NHS England cannot comment directly on the care he received. I note that your Report was also sent to Hull University Teaching Hospitals NHS Trust, and it appropriate that they respond to the Coroner's concerns specifically relating to David's care and treatment. Humber and North Yorkshire Integrated Care Board (ICB), the responsible commissioner for the Trust, is engaging with the Trust on their response and will share

this with regional colleagues in due course. We are advised that the LeDeR review[1] for David's case is ongoing, with the panel scheduled for 20th March 2025.

Reasonable adjustments and basic examinations for people with learning disabilities

The issues raised about David's care include diagnostic overshadowing, where the agitation would appear to have been attributed to his learning disability, for which reason sedative medication was administered, whereas the agitation may have been due to a physical cause such as pain or shortness of breath.

To ensure that learnings are taken, NHS England can disseminate the findings from the case of David through our network of contacts in health services. NHS England can inform the Medical Royal Colleges and the professional bodies for doctors of the lessons to be learned from the case, for dissemination to their members. The relevant professional bodies include the Royal College of Physicians (London), Royal College of Emergency Medicine, and Royal College of General Practitioners.

Staff training on the presentation of illness in people with learning disability is important in ensuring that illness is detected through careful clinical practice, which should involve reasonable adjustments during the assessment process to elicit the relevant clinical signs. The Health and Care Act 2022 introduced a statutory requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role. The Oliver McGowan Mandatory Training is the standardised training that was developed for this purpose, and is the government's preferred and recommended training for health and social care staff. All healthcare professionals are required to undertake some of the e-learning, regardless of where they work within the health system.

David was a vulnerable adult who was dependent on an elderly parent, with no other apparent social support. The welfare of vulnerable adults is largely the responsibility of local authorities and other community agencies, yet David and his father did not have contact with social care services for four days or more. A proactive system of support to David and his father could have alerted services to the perilous state that they were in. NHS England can emphasise to member agencies of Integrated Care Partnerships their important role in supporting and safeguarding vulnerable families.

NEWS2 Scores

NEWS2 is the latest version of the National Early Warning System, first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness.

[1] LeDeR reviews are undertaken to review the health and social care received by people with a learning disability and autistic people (aged four years and over) who have died, using a standardised review process. They are undertaken by Integrated Care Systems.

NEWS is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. An aggregated score of above 7 is considered high clinical risk and should trigger an urgent or emergency response by a clinician or team with competence in the assessment and treatment of acutely ill patients, including recognising when the escalation of care to a critical care team is appropriate. The response team must also include staff with critical care skills, including airway management.

In this case, where a NEWS score of 8 or 9 was recorded consistently for a number of hours, the appropriate response does not seem to have been taken.

In January 2019, NHS England, in partnership with NHS Improvement, Health Education England and the Royal College of Physicians, published the NEWS2 resource pack. Developed with clinical input, the pack provides access to tools and resources which support planning and delivery of NEWS2 implementation and illustrates practical examples of how it is being implemented across the country.

Learning from serious incidents

Your Report also raised the concern that no internal investigation or other form of serious incident investigation was undertaken.

As referenced above, NHS England has a significant learning disability mortality review (LeDeR) programme which outlines a clear expectation that "*Integrated Care Systems (ICSs) will be responsible for ensuring that LeDeR reviews are completed of the health and social care received by people with a learning disability and autistic people (aged four years and over) who have died, using the standardised review process*". A LeDeR review is currently in progress to look at the care delivered to David.

In addition, NHS England's Patient Safety Incident Response Framework (PSIRF) guidance 'Guide to responding proportionately to patient safety incidents' clearly sets out in Appendix A the '*events requiring a specific type of response as set out in policies and regulations'*. For deaths of persons with learning disabilities, trusts should *'refer for Learning Disability Mortality Review (LeDeR)'* and the guidance notes that *'Locally led PSII [patient safety incident investigation] (or other response) may be required alongside the LeDeR'*.

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 David, 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