[redacted]

Date: 12th August 2025

Moorgate Primary Care Centre
22 Derby Way
Bury
Lancashire
BL9 0NJ

[redacted]

www.bardoc.co.uk

PRIVATE AND CONFIDENTIAL
The Chief Coroner

Dear Sir/Madam

Re: Mr Andrew Dominic HEYS (Deceased) [redacted]

Official Statement from BARDOC Limited
In Response to the Section 28 Regulation Issued by HM Assistant Coroner, Mr Pollard – Bolton Coroners Court, 8th January 2025

Following the inquest held at Bolton Coroners Court on 8th January 2025, BARDOC Limited acknowledges the issue of a Section 28 Regulation (Prevention of Future Deaths) by HM Assistant Coroner Mr Pollard.

The regulation was issued after concerns were raised regarding the actions of a General Practitioner (GP) who was working on behalf of BARDOC as part of the Greater Manchester Clinical Assessment Service (GMCAS). During the inquest, the GP stated under oath that she had not received training on BARDOC's clinical pathways, and expressed confusion over accessing patient's GP records. As a result of this testimony, the Coroner concluded that a lack of training may have contributed to the incident which is under investigation.

BARDOC has since conducted a thorough internal review and investigation. We have submitted to the Coroner detailed and substantial evidence that the GP did, in fact, receive the appropriate and required training prior to recommencing work within the GMCAS. This included access to current Standard Operating Procedures (SOPs), shadowing shifts, and support resources including updated pathways and processes.

It is important to note that BARDOC was not requested to attend the inquest either as a witness or an interested party. As a result, we were unable to directly respond to the concerns raised during the proceedings.

We believe that the testimony provided by the GP at the inquest was not factually accurate, and regret that this may have influenced the Coroner's findings. It is our position that the issue did not arise due to any inadequacy in the training or support provided by BARDOC, but rather due to an unfortunate clinical decision made independently by the clinician involved.

BARDOC takes our duty of care to patients and commitment to continuous improvement extremely seriously. We are proud of our comprehensive training programmes, operational protocols, and the robust support systems available to all clinicians within our services. We will continue to work

collaboratively with Coroners, regulators, and NHS partners to ensure the highest standards of clinical governance and patient safety.

The BARDOC board has assessed this matter and concluded that a referral to the NHS Performance team is mandated. This decision has been supported by the Coroner. As the Medical Director, I am duty bound to follow the instruction and refer the matter for further investigation due to concerns mentioned earlier in this letter

We extend our sympathies to the family affected by this case, and remain committed to learning from all incidents in the interest of improving care across the healthcare system.

Yours sincerely

[redacted]

[redacted]
Medical Director