**Ms Emma Serrano**
HM Area Coroner
Stoke-on-Trent and
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Stoke Town Hall
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[redacted]

**National Medical Director**
NHS England
Wellington House
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[redacted]

6 May 2025

Dear Coroner,

**Re: Regulation 28 Report to Prevent Future Deaths – Christopher Glanville Bradbury who died on 5 January 2024.**

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 11 March 2025 concerning the death of Christopher Glanville Bradbury on 5 January 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Christopher's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Christopher's care have been listened to and reflected upon.

The first matter of concern raised in your Report was that there is a national lack of knowledge and guidelines of severe invasive soft tissue infections, that are not necrotising fasciitis.

The responsibility for clinical guidance sits with the National Institute for Health and Care Excellence (NICE) and the current relevant guidance is available here: https://www.nice.org.uk/guidance/conditions-and-diseases/infections/skin-infections/products?GuidanceProgramme=guidelines. NICE have also produced a Clinical Knowledge Summary (CKS) on impetigo and cellulitis, which include treatment options for severe infection and referral/escalation criteria for specialist input.

The UK Health Security Agency (UKHSA) are also responsible for surgical site infection (SSI) surveillance, guidance, data and analysis, which includes escalating matters to providers where appropriate. You may therefore wish to refer your concerns to NICE and/or the UKHSA.

There is an opportunity this year to revisit statutory and mandatory training for infection and prevention control and my Antimicrobial Resistance colleagues will seek to ensure emphasis on escalation of deteriorating patients.

Skin and soft-tissue infections (SSTIs) encompass a variety of pathological conditions that involve the skin and underlying subcutaneous tissue, fascia, or muscle, ranging from simple superficial infections to severe necrotising infections. The diagnosis of necrotising soft-tissue infections (NSTIs) is primarily clinical, although, radiologic imaging may be able to provide useful information when the diagnosis is uncertain.

However, it is important that if clinical suspicion of NSTI is high, radiologic imaging must neither delay nor deter surgery, because in this setting an early surgical debridement is essential to decrease mortality.

Your second concern was that actions identified in the Patient Safety Incident Investigation (PSII) have not made significant inroads or been effective. I note that you have also sent your Report to the Royal Stoke University Hospital and it is appropriate that they or University Hospitals of North Midlands (UHNM) NHS Trust to respond to you regarding this concern. NHS England Midlands regional colleagues are also in the process of engaging with Staffordshire and Stoke-on-Trent Integrated Care Board (ICB), the commissioner of UHNM, on the concerns raised by your Report for assurance purposes.

Your Report also raised the concern that there is no audit trail if a patient is not given their medication, because no signature is required for the option of recording an 'Omitted Dose'.

Prescribing information for soft tissue infections via the British National Formulary (BNF), which provides key information on the selection, prescribing, dispensing and administration of medicines for healthcare professionals, is available here: https://bnf.nice.org.uk/treatment-summaries/skin-infections-antibacterial-therapy/

Electronic Prescribing and Medicines Administration (EPMA) systems eliminate the lack of signature and accountability issue raised by the Coroner because a person would need to be logged into the system to record a missed dose and there would therefore be the requirement of a digital signature. Within EPMAs there is also the facility to include alerts that would prompt the person recording a missed dose if this were a critical drug that shouldn't usually be omitted.

All NHS Trusts should be moving towards digital EPMA systems, which will mitigate the risk of accountability for missed doses. In the absence of a signature for a missed dose, it should still be possible to identify nursing staff responsible for the care of a patient at any given time and therefore responsible for administering medicines and identifying and escalating risks such as delays to antibiotic treatment of serious infections. The Nursing and Midwifery Council's Code of Practice makes clear that patient records must be kept clear and accurate, and 'identify any risks or problems that have arisen'.

It is not possible for NHS England to provide further comment based on the information provided in your Report.

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 Christopher, 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.

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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,

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National Medical Director