NHS
Greater Manchester
Integrated Care

[redacted]

Date: 17 September 2025

Private & Confidential
Mr Michal James Pemberton
HM Assistant Coroner for the area of Manchester (West)
Manchester City Coroner's Office & Court
Exchange Floor
The Royal Exchange Building
Cross Street
Manchester M2 7EF

[redacted]

Dear Mr. Pemberton

Re: Regulation 28 Report to Prevent Future Deaths - Hailey Anne Thompson

Thank you for your Regulation 28 Report dated 7 April 2025 regarding the sad death of Hailey Anne Thompson. On behalf of NHS Greater Manchester Integrated Care (NHS GM), We would like to begin by offering our sincere condolences to Hailey's family for their loss.

Thank you for highlighting your concerns during the inquest which concluded on the 3 April 2025. Please accept my apologies for the delay in this response. We recognise it is very important to ensure we make the necessary improvements to the quality and safety of future services.

During the inquest you identified the following cause for concern:

1. **During the course of evidence, an issue was explored regarding Hailey's mother attempting to obtain an appointment or advice with the GP surgery following an apparent allergic reaction to prescribed antibiotics. These had been prescribed on 7 December for tonsilitis but stopped after three days due to an apparent allergic reaction. Regulation 28 - After Inquest Document Template Updated 30/07/2021**
2. **During a call to the GP surgery, Hailey's mother spoke with an administrative member of staff (who at the inquest was referred to as a care navigator at a call centre). The staff member referred an appointment to a pharmacist working with the practice to call her.**
3. **The pharmacist to whom this was assigned was not competent to deal with a paediatric medication enquiry and sent a message back advising of this, albeit not on the medical records system where an auditable trail would exist. On the evidence, the pharmacist was not provided with feedback directly on the need to use the medical records system or involved in the lessons learned process as they were not directly employed by the practice.**

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4. **A further concern arose during the course of evidence from the primary care practice manager that a care navigator may not have a clear pathway or [redacted] action to, or triage tool to recognise that a reported allergic reaction to a medication may require urgent consideration by a doctor to assess any risk of anaphylactic shock.**
5. **No evidence was provided to:**
   a. explain how a patient telephoning the practice and being answered by the call centre would be referred to the urgent triage doctor on duty at the practice,
   b. whether a list of clinician competencies and whom to refer tasks to was held
   c. Care Navigator training
   d. Algorithms or policies that apply to assist care navigator / call handlers at a centre which is not located within the doctor surgery.
6. **These issues are important as I had no reassurance that an administrative member of staff who spoke with a patient contacting the practice, had a clear pathway or guidance on whom the required task should be referred to.**
7. **Instead, the task could be allocated using judgement (although as above, guidance to apply this was not clear) to a clinician who could not in fact assist, which occurred in this case. The jury who heard the inquest found that there was a missed opportunity to review the antibiotics, which was not causative in this case. In my opinion, there is a risk that an urgent need for appropriate clinical referral may not occur in the above circumstances.**

I note that SSP Health have provided a response to you, and this directly addresses the issues in your report from the perspective of the provider responsible for the direct care and treatment for Hailey Anne. My response on behalf of NHS GM will refer in parts to the SSP response and outline further action and assurance that NHS GM will take.

I have addressed the causes of concern in turn below:

1. **During the course of evidence, an issue was explored regarding Hailey's mother attempting to obtain an appointment or advice with the GP surgery following an apparent allergic reaction to prescribed antibiotics. These had been prescribed on 7 December for tonsilitis but stopped after three days due to an apparent allergic reaction. Regulation 28 - After Inquest Document Template Updated 30/07/2021**

2. **During a call to the GP surgery, Hailey's mother spoke with an administrative member of staff (who at the inquest was referred to as a care navigator at a call centre). The staff member referred an appointment to a pharmacist working with the practice to call her.**

   SSP Health have explained how they managed the request for medication at that time. NHS GM does recognise that administrative staff across all our practices in Greater Manchester receive training on care navigation, signposting and advising patients on the best avenues to treatment. This could be with a GP or other allied health professionals. Whilst the nature of the training and roles can be particular to different practices. The aim is consistently to provide the best care, in the best and most efficient way for patients.

3. **The pharmacist to whom this was assigned was not competent to deal with a paediatric medication enquiry and sent a message back advising of this, albeit not on the medical records system where an auditable trail would exist. On the evidence, the pharmacist was not provided with feedback directly on the need to use the medical**

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records system or involved in the lessons learned process as they were not directly employed by the practice. [redacted]

I have reviewed the response from SSP Health to this part of your report and think there is some learning for primary care providers around ensuring efficient and effective access to the right clinician to treat them and the requirement to ensure accurate, detailed and timely record keeping. To this aim, I will ensure that:

- Working with NHS GM clinical leadership and the NHS GM primary care team, a learning document is developed to cover responsibilities for safe and effective referrals to treating clinicians, be that between practice administrative staff or clinician to clinician.
- Working with the NHS GM Information Governance (IG) team, a reminder is shared through the NHS GM Primary Care Newsletter on the requirements under GDPR of record keeping.

4. **A further concern arose during the course of evidence from the primary care practice manager that a care navigator may not have a clear pathway on whom to refer a task or action to, or triage tool to recognise that a reported allergic reaction to a medication may require urgent consideration by a doctor to assess any risk of anaphylactic shock.**

   I note that SSP Health have provided assurance that they do have referral pathways in place. The learning document described above will cover this and be shared with GM practices.

5. **No evidence was provided to:**
   a. explain how a patient telephoning the practice and being answered by the call centre would be referred to the urgent triage doctor on duty at the practice,
   b. whether a list of clinician competencies and whom to refer tasks to was held
   c. Care Navigator training
   d. Algorithms or policies that apply to assist care navigator / call handlers at a centre which is not located within the doctor surgery.

6. **These issues are important as I had no reassurance that an administrative member of staff who spoke with a patient contacting the practice, had a clear pathway or guidance on whom the required task should be referred to.**

7. **Instead, the task could be allocated using judgement (although as above, guidance to apply this was not clear) to a clinician who could not in fact assist, which occurred in this case. The jury who heard the inquest found that there was a missed opportunity to review the antibiotics, which was not causative in this case. In my opinion, there is a risk that an urgent need for appropriate clinical referral may not occur in the above circumstances.**

   I note that SSP Health have addressed this part of your report and explained how calls are managed by them and provided you with evidence to support this. Although your concerns were addressed specifically to SSP Health, there is a wider opportunity for reflection and learning, and this will come through the learning document I have described above.

   NHS GM recognises the importance of staff training in all our primary care practices to ensure that patients are navigated correctly and in a timely way as appropriate for the symptoms they are presenting with, including providing appropriate and timely treatment. NHS GM will

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ensure that the practice carries out a Significant Event Analysis (SEA) and key learning is implemented, within the provider and SSP Health as a multiple cont[redacted] the SEA and any learning with you.

On a more general note, we are also working with the GM locality leads where SSP Health has contracts to agree a more collective approach to contract and quality management, including the review of Regulation 28 Reports and the associated learning.

I hope that my response, along with the detailed response to you provided by SSP Health, has addressed your concerns. Please do contact me if I can be of further help.

Best wishes

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Interim Deputy Chief Executive Officer and Chief Nursing Officer
NHS Greater Manchester

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