Department of Health & Social Care

[redacted]
Minister of State for Health (Secondary Care)

39 Victoria Street
London
SW1H 0EU

[redacted]

HM Coroner David Heming
Coroner's Service,
Lawrence Court,
Princes Street,
Huntingdon,
PE29 3PA

[redacted]

16th October 2025

Dear Mr Heming,

Thank you for the Regulation 28 report of 7th April 2025 sent to the Department of Health and Social Care about the death of Christian James Gabriel Hobbs**.** I am replying as the Minister with responsibility for workforce.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Hobbs death, and I offer my sincere condolences to their family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention. Please accept my sincere apologies for the delay in responding to this matter.

As set out within the report, I will specifically be responding the points addressed to the Department, namely Points A, B, F, K, and L. In preparing this response, my officials have made enquiries with NHS England (NHSE) to ensure we adequately address your concerns.

There is currently no national clinical commissioning policy for Cardiogenic Shock. NHSE, via the Cardiac Services Clinical Reference Group (CRG), has received two clinical commissioning policy proposals relating to cardiogenic shock for consideration.

The CRG are aware of the cardiogenic shock network that has been developed in London and the work of the British Cardiovascular Intervention Society who are developing a working group to improve management and outcomes of cardiogenic shock provision across the UK.

NICE's Interventional Procedures Programme is looking at Insertion of a catheter-based intravascular microaxial flow pump for cardiogenic shock (IP2042). We understand that the expert working group is currently being established.

NHSE and the British Heart Foundation co-funded a sudden cardiac death pilot. This was led by the NHSE Genomics team who are considering whether they can support any lines to aid the broader response.

NHSE commissions the NHS Genomic Medicine Service (GMS) in England. Genomic testing in the NHS in England is provided through the NHS GMS and delivered by a national genomic testing network of seven NHS Genomic Laboratory Hubs (GLHs). The NHS GLHs deliver testing as directed by the National Genomic Test Directory (the Test Directory), which includes tests for over 7000 rare diseases with an associated genetic cause and over 200 cancer clinical indications, including both whole genome sequencing (WGS) and non-WGS testing. The Test Directory sets out the eligibility criteria for patients to access testing as well as the genomic targets to be tested and the method that should be used.

A key part of the NHS GMS infrastructure is seven NHS GMS Alliances which play an important role in supporting the strategic systematic embedding of genomic medicine in end-to-end clinical pathways and clinical specialities, as well as raising awareness among clinicians and the public of the genomic testing available through the NHS. NHSE has previously funded the NHS GMS Alliances to deliver a number of transformations project, including one working with Inherited Cardiac Conditions (ICC) services, the British Heart Foundation and the Chief Coroner in England and Wales to establish:

- consistent pathology referral practice for sudden unexplained deaths including use of expert pathology;
- routine tissue retention for histopathology and DNA extraction in suitable SUD cases;
- coronial and NHS communication pathways for referrals of families for genetic testing and clinical evaluation;
- mechanisms for standardised post-mortem genetic testing and reporting via NHS Genomic Laboratory Hubs;
- develop and disseminate nationally applicable best practice pathways for NHS adoption; and
- ensure the engagement and input of patient and support groups with an interest in inherited cardiac disorders

This approach has demonstrated the significant impact of partnerships in identifying family members with inherited cardiac conditions through a genomics-first approach to sudden cardiac death diagnoses. Data continues to be collected throughout 2025 to further evaluate and refine the programme.

On points F, K, and L, where you raise issues of workforce levels and training, individual NHS Trusts and other employers are responsible for ensuring that staff are, and remain, competent and capable in their area of practice.

We understand and appreciate the findings that adverse effects of antiemetics, namely cardiovascular effects may have had an impact. Universities are responsible for setting their own medical curricula, which must meet GMC standards. Postgraduate curricula are set by Medical Royal Colleges and are approved by the GMC.

Whilst not all curricula may necessarily highlight a specific condition, they all emphasise the skills and approaches a doctor must develop to ensure accurate and timely diagnoses and

treatment plans for their patients, including recognising and managing adverse reactions to prescribed drugs.

I would further expect NHS Trusts and other relevant organisations to ensure that their protocols are appropriate in the wake of the death of Master Hobbs.

In our 10 Year Health Plan we committed to publishing a new 10 Year Workforce Plan later this year. This will ensure the NHS has the right people in the right places to deliver the best care for patients.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,

MINISTER OF STATE FOR HEALTH