

**Mr Christopher Murray**  
HM Assistant Coroner  
Manchester South Coroner's Court  
1 Mount Tabor Street  
Stockport  
SK1 3AG

**National Medical Director**  
NHS England  
Wellington House  
133-155 Waterloo Road  
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20 August 2025

Dear Mr Murray,

**Re: Regulation 28 Report to Prevent Future Deaths – Neil John Clarke who died on 26 February 2024.**


Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 2 July 2025 concerning the death of Neil John Clarke on 26 February 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Neil's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Neil's care have been listened to and reflected upon.

The first concern raised in your Report was over the considerations given to the appropriateness, from a safety and wellbeing perspective, of surgical procedures involving elderly patients who may benefit from conservative measures, together with the associated documentation and guidance advising patients of different treatment choices.

Clinicians' decisions regarding appropriate care require weighing up the risks and benefits of a procedure, combined with the patient's own views, to achieve effective shared decision making.

Neil is described as a 'fit 81 year old'. The Office of National Statistics (ONS) data demonstrates that an 81 year old man has, on average, a life expectancy of 8 years ahead of them, until aged 89, and so it would seem appropriate that a fit 81 year old man would have been considered for both surgical interventions and conservative measures. However, life expectancy is also influenced by frailty and medical history. The most widely used tool for quantification of frailty in the NHS is the Rockwood Clinical Frailty Scale (CFS):

## CLINICAL FRAILITY SCALE

	<b>1</b>	<b>VERY FIT</b>	People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
	<b>2</b>	<b>FIT</b>	People who have <b>no active disease symptoms</b> but are less fit than category 1. Often, they exercise or are very <b>active occasionally</b> , e.g., seasonally.
	<b>3</b>	<b>MANAGING WELL</b>	People whose <b>medical problems are well controlled</b> , even if occasionally symptomatic, but often are <b>not regularly active</b> beyond routine walking.
	<b>4</b>	<b>LIVING WITH VERY MILD FRAILITY</b>	Previously "vulnerable," this category marks early transition from complete independence. While <b>not dependent</b> on others for daily help, often <b>symptoms limit activities</b> . A common complaint is being "slowed up" and/or being tired during the day.
	<b>5</b>	<b>LIVING WITH MILD FRAILITY</b>	People who often have <b>more evident slowing</b> , and need help with <b>high order instrumental activities of daily living</b> (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.

	<b>6</b>	<b>LIVING WITH MODERATE FRAILITY</b>	People who need help with <b>all outside activities</b> and with <b>keeping house</b> . Inside, they often have problems with stairs and need <b>help with bathing</b> and might need minimal assistance (cuing, standby) with dressing.
	<b>7</b>	<b>LIVING WITH SEVERE FRAILITY</b>	<b>Completely dependent for personal care</b> , from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).
	<b>8</b>	<b>LIVING WITH VERY SEVERE FRAILITY</b>	<b>Completely dependent for personal care</b> and approaching end of life. Typically, they could not recover even from a minor illness.
	<b>9</b>	<b>TERMINALLY ILL</b>	Approaching the end of life. This category applies to people with a <b>life expectancy &lt;6 months</b> , who are <b>not otherwise living with severe frailty</b> . (Many terminally ill people can still exercise until very close to death.)

### SCORING FRAILITY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting. In **severe dementia**, they cannot do personal care without help. In **very severe dementia** they are often bedfast. Many are virtually mute.



Clinical Frailty Scale ©2005-2020 Rockwood, Version 2.0 (EN). All rights reserved. For permission: [www.geriatricmedicine.ca](http://www.geriatricmedicine.ca)  
Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

An 81 year old man with a CFS of 7 entering a nursing home has a life expectancy, on average, of little over a year. Reciprocally, a 'fit' 81 year man (CFS 1-2) will have, on average, a life expectancy of 9 years or more.

To be able to achieve effective shared decision making on treatment choices also requires information on the potential risk/benefits of the different surgical options. NHS England notes from your Report that different options were provided and discussed with Neil, to include conservative management, further polypectomy or a right hemicolectomy, the latter being advised as the most appropriate option by clinicians.

There is clear national guidance on perioperative care for both adults and specifically older people from the National Institute for Health and Care Excellence (NICE) and the British Geriatrics Society (BGS) respectively.

- **NICE Guidance NG180: Perioperative care in adults (published 19 August 2020)**

[Recommendations](#) | [Perioperative care in adults](#) | [Guidance](#) | [NICE](#)

- **BGS Good Practice Guide: Peri-operative Care for Older Patients Undergoing Surgery (published 23 January 2015)**

[Peri-operative Care for Older Patients Undergoing Surgery | British Geriatrics Society](#)

NHS England has also undertaken considerable work to develop the following guidance on [Early screening, triaging, risk assessment and health optimisation in perioperative pathways: guide for providers and integrated care boards](#) (published in May 2023 prior to Neil's death and updated in May 2025), which includes information on risk assessment and shared decision making. Point 5 under the 'Five core requirements for providers' states:

*"Patients must be involved in shared decision-making conversations to discuss the benefits, risks, alternatives and likely outcomes of the surgery, as well as the postoperative recovery period. This allows patients to confirm their decision to proceed with the surgery, seek further specialist advice if required or make the informed choice to pursue alternative options".*

Our [Personalised Care](#) Team have also produced supporting information on shared decision making including '[Decision support tools](#)' resources, also called patient decision aids, to support shared decision making by making treatment, care and support options explicit.

It is outside of NHS England's remit to provide comment on the appropriateness of the clinical decision to proceed with a right hemicolectomy in Neil's case. The clinical team at Stepping Hill Hospital would be best placed to comment upon the specific circumstances of this case.

Your second concern focused on the accuracy of handover communications between clinical staff regarding patients returning to the main ward from the High Dependency Unit (HDU) at Stepping Hill Hospital.

Safe and appropriate handover of patients is a basic and core aspect of all clinical care. We refer the Coroner to Stockport NHS Foundation Trust's response to your Report, on behalf of Stepping Hill Hospital, regarding this concern. NHS England has also asked to be sighted on their response and will consider this carefully.

I would also like to provide further assurances on national the 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 Neil, 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,



National Medical Director  
NHS England