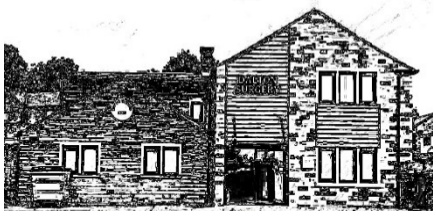

Dalton Surgery

www.DaltonSurgeryHuddersfield.com
[redacted]

Mr Crispin Oliver
HM Assistant Coroner
West Yorkshire (Western) Coroner Area
HM Coroner's Court
Cater Building
1 Cater Street
Bradford
BD1 5AS

[redacted]

5 September 2025

Dear Mr Oliver,

Re: Regulation 28 Report to Prevent Future Deaths – Myles Edward Scriven

We write in formal response to the Regulation 28 Report issued to Dalton Surgery on 17 July 2025, with submission requested by 8 September 2025, concerning the tragic circumstances surrounding Mr Myles Edward Scriven (MS).

Firstly, on behalf of the GP partners and all staff at Dalton Surgery, we extend our deepest sympathies to Mr Scriven's family. We wish to assure you that we have taken the concerns raised in the Regulation 28 Report, and the family's feedback, very seriously. Our priority is to ensure that such a situation does not reoccur for other patients.

In this response, we address the three key areas of concern highlighted in your notice. To support the GP Partners in comprehensively addressing these issues, we have enclosed a detailed action plan. This plan outlines specific measures, assigns named accountable leads, includes auditable evidence, and sets clear timescales for monitoring through our Bimonthly Practice Protected Time (PPT) meetings. Working collaboratively with our ICB colleagues, progress will also be reported to the place-based Quality Sub Committee and a full review of actions will be undertaken at a six month follow up meeting involving key stakeholders.

Since receiving the Regulation 28 notice, we have implemented a range of actions to enhance patient safety, strengthen clinical practice, and embed learning throughout the practice. We also provided NHS England ([redacted], Head of Clinical Quality, Northeast and Yorkshire) with written assurance on 29 July 2025 regarding progress in these areas.

1. **Understanding and Supporting Patients with Learning Disabilities and Autism**

We acknowledge that our practice historically did not have sufficiently robust systems in place to ensure consistent, proactive care for patients with Learning Disabilities (LD) and Autism. Specifically, there was variable awareness amongst staff of the additional challenges faced by these patients in expressing symptoms, the need for collateral history from carers, and the importance of reasonable adjustments in clinical practice.

Summary of key actions undertaken:

a) Designated three Learning Disability (LD) and Autism champions: a GP, a nurse, and an administrative team member. The role of the LD Champions will include advocacy and support for patients, improving health outcomes and wider primary care engagement.
b) All practice staff have completed Oliver McGowan Level 1 training, with Level 2 training scheduled for October 15th and 28th 2025.
c) New administrative staff receive mandatory LD training before commencing duties; locum doctors are provided with LD awareness packs.
d) Implemented standard reasonable adjustments for patients, including extended appointment times, easy-read correspondence, health passports, and proactive recall systems.
e) Practice Manager received bespoke training on discussing reasonable adjustments with patients.
f) Engaged with Jessica Atkinson (Strategic Health Facilitator for Kirklees Adult Learning Disability) to jointly review the LD register and enhance communication aids, recall processes, and patient resources. A follow-up visit is planned for October 2025.
g) Extended appointment length for LD and Autism Health Checks from 45 minutes to one hour.
h) Embedded improved safety-netting practices and clinical tools (CURB-65, MEWS, CHA2DS2-VASc) to ensure systematic patient assessments and recalls.
i) Added patient icons in SystmOne to flag LD and Autism status; employed a dedicated coder to maintain accurate records.
j) Scheduled Capacity and Consent training for designated GP with DAC Beachcroft on 8th October 2025.
k) Adjusted invitation scheduling for LD health checks to ensure all patients are invited appropriately, with staff trained on tailored invitation management.

These measures reflect both training completion and practical application, safeguarding patients with LD and ensuring prioritised, appropriate care.

The Practice plans to undertake bi-monthly audits of all patients on the LD Register to confirm its accuracy and updated care plans and hospital passports where necessary. The purpose of the audit is to affirm that the LD Register is being used with 100% accuracy and regular audits will continue to be carried out. Please refer to the attached action plan for audit details and scheduling.

2. **Improvement in Recording of Clinical Observations**

We fully acknowledge the Coroner's concern that the GP consultation on 20 March 2023 did not include adequate recording of numeric observations (e.g. oxygen saturation, pulse, respiratory rate).

Reflection from GP (also stated during the Inquest)

"I acknowledge that my consultation record was poor and lacking in important details – particularly quantitative values for examination findings. This is not usual for my way of working. I am confident that such observations were in fact undertaken and were satisfactory, but unfortunately, they were not recorded. In light of this, I have changed my practice: I now use internal systems and templates to prompt and facilitate proper capture of these values in every consultation."

Summary of key actions undertaken:

a) Reiterated the importance of thorough documentation of vital clinical observations during consultations, particularly for acute symptoms such as breathlessness, through targeted clinical safety refresher training where needed.
b) Introduced enhanced triage protocols and promoted face-to-face assessments when clinically indicated.
c) Reminded clinical staff of documentation's role in decision-making and safety-netting; compliance monitored via audits and peer reviews, detailed in the enclosed action plan.
d) Implemented consultation templates, digital prompts, Ardens templates, and AI-supported dictation/scribing tools to improve accuracy.
e) Adopted a low threshold for same-day reviews or A&E referral for patients presenting with breathlessness.
f) Provided additional training for administrative staff to escalate urgent symptoms promptly.
g) Recent case reviews demonstrate effective triage and urgent management of patients presenting with breathlessness, including timely admissions and diagnoses of pulmonary embolism.
h) The practice has recognised the necessity of immediate same-day review or direct A&E referral for breathlessness presentations, now standardised in our clinical approach.

The Practice plans to undertake monthly audits of 20 consultations for the three months to assess compliance with observation documentation. Our target will be 100% compliance consecutively on each occasion.

3. **Learning from Significant Events and Internal Reviews**

We accept that, immediately after Myles' death in April 2023, our internal review processes were not as rigorous or structured as they should have been. While reflection occurred, the depth and documentation of this initial review did not fully meet expected governance standards.

Summary of actions undertaken:

a) Conducted two Practice Protected Time (PPT) sessions in June and October 2023 focusing on clinical decision-making, triage, and prevention.
b) Held two further Significant Event Analyses (SEAs) in April and July 2025 to review the case and coroner's findings.
c) All clinical staff participated; [redacted] acknowledged Myles should have been referred to secondary care between 16 – 20 March 2023 and that the failure to do so made a direct contribution to his death.
d) Enhanced policies and processes for incident reviews now include clearer documentation, minutes, and explicit learning outcomes.
e) Promoted an open culture of reporting, reflection, and continuous learning.
f) Updated the Practice Significant Event Policy, accessible on Microsoft Teams and in hard copy with signed staff acknowledgements, is being aligned with the NHS England Patient Safety Incident Response Framework (PSIRF) and the Primary Care Patient Safety Strategy for GP practices.
g) Bimonthly PPT meetings regularly incorporate SEA discussions and policy review to reinforce staff understanding.

Going forward, the Practice will schedule quarterly Learning from Events meetings to review SEAs and share learning from both internal and external cases to promote shared learning. The first quarterly meeting is scheduled for January 2026.This will be in line with the Primary care patient safety strategy and Learning from Patient Safety Events (LFPSE).

This comprehensive approach ensures thorough investigation, learning, and sustained improvements in patient safety.

4. **Support from System Partners and Collaborative Networks**

As a GP practice in Kirklees we:

a) Benefit from the Strategic Health Facilitator for Kirklees Adult Learning Disability (SWYPFT), providing training and support across local GP practices.
b) Utilise Kirklees Get Checked Out resources and LD-friendly template letters uploaded in SystmOne for consistent communication.
c) Following migration to SystmOne, collaborated with the ICB Data Quality team to verify and ensure accurate coding of patients with LD and Autism.
d) Participate in the Tolson Primary Care Network's 'Mondays at the Museum' Creative Health initiative, promoting wellbeing activities in a stigma-free environment, actively encouraging patients with LD and Autism to engage.

Dalton Surgery has taken robust and sustained action in response to the Regulation 28 report. We have strengthened clinical processes, embedded new policies, enhanced training, and fostered a culture of transparency and continuous improvement.

We trust this response and the enclosed action plan demonstrate the significant steps we have already taken and that you are assured of our commitment to delivering safe, inclusive, and accountable care. We would be happy to provide any further information or supporting documentation as required.

Yours sincerely,

[redacted]

GP Partners

Enc: Action Plan

Cc:

[redacted] Medical Director, NHS England (Yorkshire and the Humber)
[redacted] Medical Director, West Yorkshire Integrated Care Board
[redacted], Accountable Officer – Kirklees, WYICB
[redacted], Director of Primary Care, WYICB
[redacted], Primary and Community Care Inspector, CQC
[redacted], Head of Clinical Quality, NHS England – NE and Yorkshire