NHS England

Mr Crispin Oliver
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West Yorkshire (Western) Coroner Area
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Bradford
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National Medical Director
NHS England
Wellington House
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[redacted]

2 September 2025

[redacted]

Dear Mr Oliver,

Re: Regulation 28 Report to Prevent Future Deaths – Myles Edward Scriven who died on 16 April 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 14 July 2025 concerning the death of Myles Edward Scriven on 16 April 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Myles' family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Myles' care have been listened to and reflected upon.

Your Report raises concerns that Myles' GP surgery were ignorant of the regulatory requirements and reasonable adjustments required for Myles in light of his learning disability and autism, that they failed to record numeric observations properly, and that they failed to undertake a detailed and rigorous internal review for learning purposes following Myles' death.

Learning disability information

A learning disability is defined by the Department of Health and Social Care (DHSC) (2001) as a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood.

A learning disability is different for everyone. The degree of disability can vary greatly, being classified as mild, moderate, severe, or profound. In all cases, a learning disability is a lifelong condition and cannot be cured.

A learning disability is different to a learning difficulty, which is a reduced ability for a specific form of learning and includes conditions such as dyslexia (reading), dyspraxia (affecting physical co-ordination), and attention deficit hyperactivity disorder (ADHD). A person with a learning disability may also have one or more learning difficulties.

Training requirements

Under the Health and Care Act 2022, since 1 July 2022, Care Quality Commission (CQC) registered providers have been required to ensure that their staff, including

GPs, receive specific training on learning disability and autism appropriate to their role. On 19 June 2025, NHS England published a Code of Practice which sets out expectations for training content and delivery. This training helps to ensure that staff have the right knowledge and skills to provide safe and informed care.

To support this, we have been rolling out the Oliver McGowan Mandatory Training on Learning Disability and Autism to the health and adult social care workforce. The training includes content on understanding learning disability and autism, frequently co-occurring conditions, reasonable adjustments, and reflection on own attitudes and professional behaviour. Over 3 million people have completed the e-learning package which is the first part of Oliver's Training, and is freely available on the Elearning for Health Hub.

Health checks and reasonable adjustments

NHS England is working with the Royal College of GPs and other stakeholders to improve the quality of annual health checks for people with a learning disability and will be publishing a framework for annual health checks in coming months.

In providing the learning disability health check scheme, GP practices are encouraged to provide a more proactive and coordinated approach to care, improving liaison with carers and secondary care, and developing a health action plan with individual patients in response to their needs.

The Equality Act 2010 places a legal duty on health and care services to make changes to their approach or provision to ensure services are as accessible for people with disabilities as they are for everyone else. NHS England has introduced the reasonable adjustment digital flag to enable health and care services to record, share and view details of the reasonable adjustments a person needs to support their care.

Organisations are required to use their own systems and processes to record reasonable adjustment needs, and staff e-learning training has been rolled out for all health and care staff to support this.

Accurate recording

The GP contract requires that accurate patient records are maintained, including for patients with a learning disability. The Learning Disabilities Health Check Scheme continues to be offered via the Direct Enhanced Services Directions, to encourage the maintenance and updating of learning disability registers and the completion of annual health checks and health action plans for each registered patient aged 14 years and over on the learning disabilities register. The Investment and Impact Fund continues to directly incentivise delivery of annual health checks and health action plans.

NHS England has also produced guidance for general practice on Improving identification of people with a learning disability.

ICB contract management of GP practices

Integrated Care Board (ICBs) are responsible for the commissioning and contract management of GP practices. ICBs will undertake intelligence led and routine contractual reviews based on a combination of national and local data sources, alongside other soft intelligence, and practice visits to identify practice variation and improvement needs. NHS England publishes guidance for ICBs, which includes an assurance framework for contractual reviews.

As part of these reviews, NHS England would expect ICBs to ensure GP practices have processes in place for learning from patient safety events. The national GP contract has introduced new requirements in 2025/26 to ensure practices have regard to the primary care patient safety strategy published in September 2024, and are registered with the learn from patient safety events service (LFPSE) for the purposes of:

- recording patient safety events at the practice about the services delivered by the practice, thereby contributing to the national NHS-wide data source to support learning, improvement and learning culture.
- enabling the practice to record patient safety events occurring in other health care settings (for instance if a GP practice wished to record an unsafe discharge from hospital).
- individuals recording patient safety events being able to download a copy of the record for purposes of supporting appraisal and revalidation.

GP practices are now required to declare annually their compliance which, alongside data from the LFPSE, will support the ICB contractual review processes described.

Regional learning and improvements

My regional clinical quality colleagues for the North East and Yorkshire region have also been engaging with NHS West Yorkshire Integrated Care Board on the concerns raised in your Report.

The ICB is undertaking a LeDeR review to understand what local learning can be taken from this tragic death and will implement actions at a local level because of their findings.

NHS England is advised by the ICB that the GP surgery involved in Myles' care has taken learnings from Myles' death. These include:

- Improved processes for the management of patients with learning disabilities and autism, to include all staff completing the Oliver McGowan training and adopting a low threshold for offering face-to-face reviews for patients with learning disabilities.
- Reminding clinical staff of the importance of accurate documentation for clinical decision-making, safety netting and continuity of care, which will be monitored through protocols and audits.
- Undertaking Practice Protected Time meetings and Significant Event Analyses (SEAs) to discuss Myles' care and lessons learned (early triage of breathless patients, same day face-to-face review of patients, etc.)

We refer the Coroner to the GP surgery's response to you for further information.

I would also like to provide further assurances on the 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 Myles, 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