Ms Sonia Hayes
Area Coroner
Essex and Thurrock Coroner's Service,
Essex County Council,
Seax House,
Victoria Road South,
Chelmsford,
CM1 1QH

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

6 October 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Quy Thi Pham who died on DATE.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 11 August 2025 concerning the death of Quy Thi Pham on 3 September 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Quy's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Quy's care have been listened to and reflected upon.

Your report raised concerns relating to the existing National Cervical Screening Guidance for pregnant women. In particular, you highlighted the Trust Consultant's concerns that the Guidance may mean that a cohort of women may be excluded, specifically in relation to bleeding as a symptom of concern. This is because not all post-partum women have resumed coitus (leading to post-coital bleeding), post-partum bleeding can persist or be misinterpreted and therefore not understood to be abnormal, and women in general may not have a regular menstrual cycle making it difficult to diagnose bleeding. In addition, rare complications of early stage cervical cancer may not always manifest with bleeding symptoms.

The Cervical Screening Programme

The aim of the national cervical screening programme is to detect asymptomatic cell changes in the cervix that could, if left untreated, develop into cervical cancer in the future. The screening programme guidance for patients with unusual bleeding or gynaecological symptoms they are concerned about is always to seek advice from their GP. A cervical screening test is not an appropriate tool to investigate these concerns as it is not a diagnostic test.

Based on the information within your Report, it appears that the NHS Cervical Screening Programme guidance was followed in Quy's situation. The guidance is that

screening should be delayed if it is less that 3 months since the person gave birth, as the results may not be reliable due to the disruption to the epithelium of the cervix during birth and so could be falsely reassuring if a normal result is issued.

Screening programme advice on the management of abnormal bleeding is available: Abnormal vaginal bleeding in women under 25: clinical assessment - GOV.UK and Cervical screening: programme and colposcopy management - GOV.UK (individuals with symptoms and cervical screening in pregnancy).

Based on the clinical history provided which has been reviewed by clinical experts who support NHS England's cervical screening team, Quy suffered from an aggressive form of cervical cancer which metastasised to the lungs at presentation. It is accepted that unusual and rapidly developing cervical cancers are unlikely to be prevented by screening. Even if Quy had received post-natal screening in July 2024, on the balance of probabilities, Quy would still have had an aggressive cervical cancer with lung metastases which, sadly, would still have been incurable.

There is research underway supported by the cervical screening programme to collect evidence on whether it is safe, accurate and reliable to report cervical screening tests within 3 months of birth. This research is expected to conclude by September 2027. When the findings of this research are available, NHS England will consider them and update national guidance accordingly.

GP Surgery Key Learnings

I understand that Quy's GP Surgery undertook a comprehensive review of her records and completed a Significant Event Analysis.

The key learnings highlighted by the surgery include the introduction of mandatory prompts during postnatal checks to ask and record bleeding symptoms. Whilst completing new baby registrations, administrators will now check and book maternal postnatal and cervical screening appointments. Training on screening has also been undertaken, including the clarification of the referral pathway for abnormal bleeding which should trigger urgent gynaecological referral and not screening.

In addition, the surgery will flag vulnerable groups in their records (e.g. language barriers, never-screened, immunocompromised) and apply tailored communication strategies to ensure equitable access to screening.

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 Quy, 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,

[redacted]

[redacted]
National Medical Director
NHS England