Karen Henderson

HM Assistant Coroner for West Sussex, Brighton and Hove.

Parkside Chart Way

Horsham

RH12 1XH

[redacted]

11 November 2025

[redacted]

Dear HM Assistant Coroner Karen Henderson,

Regulation 28 Report following the inquest into the death of Mr Keith James Hankin

Thank you for bringing the Regulation 28 Report to our attention following the inquest into the death of Mr Keith James Hankin at Worthing Hospital on 11 September 2023. We acknowledge the concerns raised and appreciate the opportunity to respond.

We would like to express our sincere condolences to Mr Hankin's family and loved ones following his death.

We have noted the matters of concerns listed below:

1. **Lack of clinical governance in the Community Urology Service (CUS) by the Integrated Care Board (ICB) who commissioned the service and Sussex Medical Chambers (SMC) who were responsible for providing the service.**
2. **Lack of integration of the Community Urology Service with NHS Hospital Urology Services.**
3. **Lack of appraisal and mandatory assessment of clinicians employed by CUS.**
4. **Practicing Privileges in the private sector.**
5. **Learning from Mr Hankin's death.**
6. **Management of Mr Hankin at Goring Hall Hospital.**

While the Care Quality Commission (CQC) has statutory powers to regulate providers of health and social care services, we do not hold regulatory authority over Integrated Care Boards (ICBs). Responsibility for the oversight, governance, and performance of ICBs lies with NHS England.

In response to the points raised.

1. **Lack of clinical governance in the Community Urology Service (CUS) by the Integrated Care Board (ICB) who commissioned the service and Sussex Medical Chambers (SMC) who were responsible for providing the service.**

The Integrated Care Board contracted Sussex Medical Chambers to provide a Community Urology Service through any qualified provider in 2015 and renewed the contract through a competitive tendering process twice subsequently. The ICB used a generic contract supplied by NHS England to contract the service. Neither the ICB nor SMC were able to provide any evidence of robust clinical governance or multi-disciplinary team processes to ensure best practice of urology services from inception to date.

We are unable to comment on the aspects of this concern that relate to the Integrated Care Board (ICB) as it falls outside of the scope of our regulatory responsibilities. The Integrated Care Board (ICB), as a named respondent in this case, would be best placed to address this point and provide further clarification.

We have responded to the aspects relating to Sussex Medical Chambers (SMC).

We use regulations when we assess if a provider is safe, effective, caring, responsive and well-led. Regulations for service providers and managers - Care Quality Commission

The lack of robust clinical governance arrangements and multidisciplinary team (MDT) assessment within the Community Urology Service (CUS) provided by SMC is covered under the following regulation:

- Regulation 17: Good governance

To meet the regulation, providers must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service.

We last inspected Sussex Medical Chambers (SMC) in November 2022. At the time, governance structures, processes, and systems were clearly defined and understood. Leaders held regular update meetings, supported by an effective staff meeting structure for cascading information. Service-specific team meetings reviewed standing agenda items such as complaints, incidents, and patient feedback, with minutes circulated to all staff. Quarterly clinical governance meetings assessed service delivery and, where necessary, individual patient care to optimise outcomes and share learning.

The provider maintained an incident and complaints log to identify risks, investigate issues, and implement corrective actions. Incidents were reviewed in team and governance meetings, with reporting processes fostering openness and transparency. Timely actions were taken to address issues.

As an NHS-commissioned provider, SMC monitored and reported key performance indicators (KPIs) such as infection rates, patient satisfaction, safety incidents, complaints, and waiting times. The provider worked closely with commissioners to review service quality and patient outcomes, supported by documented meeting minutes and audits aligned with agreed KPIs.

However, we acknowledge that this inspection took place approximately 1 year prior to the death of Mr Hankin.

In response to the Regulation 28 report and as part of our regulatory response, we asked Sussex Medical Chambers (SMC) to tell us how they have responded to this element of the Regulation 28 report.

They submitted documentation of clinical governance meetings held regularly, 3 to 4 times per year, from 2020 to 2025. We reviewed the minutes and found that they demonstrated regular review of incidents, safeguarding concerns, and complaints related to all aspects of their service, including the Community Urology Service (CUS). The death of Mr Hankin was discussed at meetings on 1 November 2023, 7 March 2024, and 15 May 2025. Additionally, the records indicated that SMC engaged with Goring Hall Hospital (GHH), expressing willingness to participate in their investigation. Further correspondence was noted, requesting the investigation findings and seeking opportunities for organisational learning.

Furthermore, the minutes reported on patient satisfaction, highlighting strong participation and high recommendation scores. They also documented SMC's attendance at quarterly contract review meetings with the Integrated Care Board (ICB), where performance metrics including quality indicators and the achievement of Commissioning for Quality and Innovation (CQUIN) targets were met and discussed in accordance with the NHS Standard Contract.

We were satisfied that the evidence provided demonstrated acceptable arrangements under Regulation 17: Good Governance.

2. **Lack of integration of the Community Urology Service with NHS Hospital Urology Services.**

   The CUS provided community-based urology services with non-consultant grade urologists without any oversight or integration with hospital-based consultant led urology services. Whilst there was an opportunity for CUS to refer more complex patients to NHS Hospital Trusts the 'silo' effect of these 2 services was such that they effectively worked independently of each other. The absence of a robust multidisciplinary team assessment within the CUS and the lack of senior clinical oversight of community urology patients by NHS consultant clinicians leads to a concern that the urology service is fragmented and does not effectively support urology patients within the region to confirm best practice and optimal treatment.

We are unable to comment on the aspects of this concern that relate to the Integrated Care Board (ICB) as it falls outside of the scope of our regulatory responsibilities. The Integrated Care Board (ICB), as a named respondent in this case, would be best placed to address this point and provide further clarification.

We have responded to the aspects relating to Sussex Medical Chambers (SMC).

In response to the Regulation 28 report and as part of our regulatory response, we asked Sussex Medical Chambers (SMC) to tell us how they have responded to this element of the Regulation 28 report.

SMC told us that they understood this concern to have arisen from Mr Al-Singary's decision to refer Mr Hankin to Goring Hall Hospital (an independent hospital) and not to Worthing Hospital (an NHS hospital) given his co-morbidities. They acknowledged the concern and introduced a Referral Risk Assessment Checklist, to be completed by clinicians within the Community Urology Service (CUS) for all surgical referrals. This checklist has been designed to support appropriate patient selection and ensure optimal treatment pathways and will be audited monthly. We have reviewed the checklist and concluded that it provides a clear and structured approach to aid clinicians in making appropriate onward referrals to suitable secondary care providers.

SMC provided evidence of multidisciplinary team (MDT) meetings where individual patients were discussed on 25 July 2024, 12 November 2024, 14 January 2025, and 10 May 2025. However, we acknowledge that Mr Hankin's death occurred prior to these formally documented MDT meetings.

SMC informed us that they have developed and implemented a Communication Improvement Plan to further address concerns raised regarding referral pathways and siloed working. The plan also responds to issues around the absence of a formal process for following up clinical incidents in collaboration with other agencies.

They presented details of the staff engaged under practising privileges to provide the Community Urology Service (CUS). We cross referenced this information with the General Medical Council (GMC) register and confirmed that both lead urology consultants, along with 3 of the 4 other Urologists, are listed on the GMC Specialist Register, indicating they are qualified to practise as consultants. The fourth urologist is registered with the GMC but not at consultant level. The registered nurse is listed on the Nursing and Midwifery Council (NMC) register with no restrictions on their practice. We noted that all but 1 of the clinicians held NHS roles as their primary employment.

Based on this, we were satisfied that the service was consultant-led and that action has been taken to address referral concerns and silo working through the introduction of the Referral Risk Assessment Checklist and Communication Improvement Plan.

3. **Lack of appraisal and mandatory assessment of clinicians employed by CUS.**

There was an absence of any appraisal and/or mandatory assessments within the CUS or the ICB and SMC for the associate specialist clinicians who were working extra-contractually outside of their NHS work. No evidence was provided as to their experience and competency. This gives rise to a concern that their working practices are insufficiently assessed and fails to fulfil GMC 'good practice' guidelines. Likewise, no evidence was provided regarding regular morbidity and mortality reviews of complications by the ICB, CUS and SMC such as when patients re-present to NHS hospitals with complications arising from the CUS.

We are unable to comment on the aspects of this concern that relate to the Integrated Care Board (ICB) due to it being outside of the remit of our regulatory scope. The ICB as a named respondent in this case, would be best placed to address this point and provide further clarification.

However, we have responded to the aspects relating to Sussex Medical Chambers (SMC).

We use regulations when we assess if a provider is safe, effective, caring, responsive and well-led. Regulations for service providers and managers - Care Quality Commission

The concern regarding the lack of appraisal and mandatory assessment of clinicians employed by CUS is covered under the following regulations:

- Regulation 17: Good governance
- Regulation 18: Staffing
- Regulation 19: Fit and proper persons employed

To meet the regulation, providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times and the other regulatory requirements set out in this part of the above

regulations. Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. They should be supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator to show that they meet the professional standards needed to continue to practise.

We last inspected Sussex Medical Chambers (SMC) in November 2022. At that time, we found that the service had systems for regular reviews of individual staff performance. Staff participated in routine one-to-one meetings with their clinical line managers and received annual appraisals. Those who had completed their probationary period underwent a formal probationary review. Clinical staff working on a sessional basis were required to provide evidence of their external professional appraisal summaries to the provider. The service held records confirming that medical professionals were registered with the General Medical Council (GMC) and were up to date with their revalidation requirements.

However, we acknowledge that this inspection took place approximately 1 year prior to the death of Mr Hankin.

In response to the Regulation 28 report and as part of our regulatory response, we asked Sussex Medical Chambers (SMC) to tell us how they have responded to this aspect of the Regulation 28 report.

SMC informed us that they had previously provided your office with an explanation of the appraisal process, as outlined in the Managing Director's statement dated 27 June 2025. The same information was subsequently shared with us.

They informed us that all clinicians working within the Community Urology Service (CUS) hold primary clinical roles elsewhere, typically within NHS Trusts, and work with their organisation in a secondary capacity. Their primary employers are responsible for conducting annual appraisals, which include reviewing previous appraisals, verifying continuing professional development (CPD) and mandatory training, considering feedback, and assessing any serious incidents or complaints. They explained that it is standard practice for the primary appraiser to seek input from CUS, which they consistently provide upon request. They also confirmed that they receive and review each clinician's appraisal documentation annually as part of their internal governance process.

In addition, the provider conducts its own annual review with each clinician, tailored to their role and seniority. This includes compliance checks, confirmation of up-to-date mandatory training and CPD, and a review of patient feedback.

We were satisfied that this demonstrated that appraisals were performed in line with nationally recognised arrangements for individuals working in the independent sector.

4. Practicing [sic] Privileges in the private sector.

[sic] set up and led the CUS under the auspices of SMC. The ICB contractually required this service to be run by a consultant urologist. [sic] had not held a formal consultant urologist position within the NHS prior to tendering for this work. It remains unclear as to how [sic] was provided with practicing [sic] privileges at a private hospital as a consultant and was therefore able to practice independently and without scrutiny. This gives rise to a concern that there is a lack of robust assessment and guidelines, both locally and nationally, as to how clinicians are given practicing [sic] privileges to

work independently outside of the NHS to the potential detriment of patient care. It also gives rise to a concern that patients are not being fully informed of the relevant experience of such clinicians thereby breaching the statutory duty of candour responsibility of all hospitals.

We are unable to comment on the aspects of this concern that relate to the Integrated Care Board (ICB) due to it being outside of the remit of our regulatory scope. The ICB as a named respondent in this case, would be best placed to address this point and provide further clarification.

We recognise that the General Medical Council (GMC) is responsible for ensuring that all doctors, physician associates (PAs), and anaesthesia associates (AAs) practising in the UK have the appropriate knowledge, skills, qualifications, and experience. They fulfil this role by maintaining official registers of these professionals. We are unable to comment on the GMC regulatory responsibilities. The GMC is best placed to respond to this aspect of this question. However, we note that the GMC is not a named respondent.

When we inspect independent providers, we check that they have processes for managing practising privileges, including that they have processes for checking that doctors, physician associates (PA) and anaesthesia associates (AA) are registered with the GMC. We understand from our review of the GMC Register that the individual referenced has been registered as a consultant on the GMC Specialist Register (Urology) since 2008.

When we last inspected Goring Hall Hospital (GHH) in December 2021, we found that consultants working under practising privileges were required to submit appraisal documentation to the registered manager prior to commencing work and annually thereafter. The Medical Advisory Committee (MAC) was responsible for overseeing clinical governance, approving and renewing practising privileges, and monitoring patient outcomes.

However, we acknowledge that this inspection took place approximately 2 years prior to the death of Mr Hankin.

When we inspected Sussex Medical Chambers (SMC) in November 2022, we found staff had the appropriate skills, knowledge, and experience for their roles. Induction and training were well structured, with protected time for learning. Practising privileges were granted to experienced consultants across multiple specialties. Records of qualifications and training were generally well maintained. Staff performance was regularly reviewed through one-to-one meetings, probationary reviews, and annual appraisals. Sessional clinical staff submitted external appraisal summaries. The service held records confirming that medical professionals were registered with the GMC and up to date with revalidation.

However, we acknowledge that this inspection took place approximately 1 year prior to the death of Mr Hankin.

In response to the Regulation 28 report and as part of our regulatory response, we asked Goring Hall Hospital (GHH) and Sussex Medical Chambers (SMC) to tell us how they have responded to this aspect of the Regulation 28 report.

Goring Hall Hospital (GHH) informed us that, while they did not consider this concern to be specifically directed at their organisation, they understood it was prompted by the use of the title “consultant” by Mr Hankin’s treating surgeon at GHH when he had not held a consultant post in the NHS. They clarified that the surgeon in question had worked in the NHS for 18 years prior to retiring to focus on his private practise.

As we had already identified, they clarified that the surgeon had been on the GMC Specialist Register since 23 April 2008, confirming that he meets GMC standards to “work at any grade in the NHS including consultant”.

GHH also provided Circle Health Group (CHG) Practising Privileges policy which aligns with the Independent Healthcare Providers Network (IHPN) Medical Practitioners Assurance Framework (MPAF), refreshed in September 2022. They confirmed that the treating surgeon satisfied the requirements of the policy and holds practising privileges at GHH as a consultant urologist.

They informed us that CHG policies are regularly reviewed under its medical governance framework to remain in-keeping with best practice. Having considered the coroner’s concerns carefully, CHG was satisfied that no additions or changes to its current processes were required, and that medical practitioners working within its facilities had the necessary qualifications and expertise to do so.

GHH also provided CHG Responding to Concerns about Medical Practitioners policy which offered a clear, formal framework in order to address issues of concerns which arise in relation to medical practitioners who are working under practising privileges.

We reviewed the response from GHH, both policies and the IHPN Medical Practitioners Assurance Framework (MPAF), reference by GHH. We were satisfied that both policies provided robust guidelines, aligned with national guidance.

Medical Practitioners Assurance Framework (MPAF) refresh - Independent Healthcare Provider Network

Sussex Medical Chambers (SMC) advised that they understood this concern to be directed at Goring Hall Hospital (GHH) and had covered the aspects in relation to [redacted] CV in their response to earlier concerns. We were satisfied that SMC had provided appropriate evidence in response to those earlier concerns.

5. Learning from Mr Hankin’s death.

The ICB did not independently review the circumstances of Mr Hankin’s death to confirm if there was any learning or changes in practice to prevent further deaths. Likewise, SMC relied on [redacted] to inform them and investigate Mr Hankin’s death without considering the inherent conflict of interest in so doing. The lack of an independent review prevented any proactive learning and changes in practice following the death of Mr Hankin. This gives rise to a concern that the system within the ICB and SMC are insufficiently robust and could – as it was with Mr Hankin – prevent transparency and openness as to the circumstances of his death and limit any learning and or necessary changes in practice to prevent future deaths.

We are unable to comment on the aspects of this concern that relate to the Integrated Care Board (ICB) due to it being outside of the remit of our regulatory scope. The ICB as a named respondent in this case, would be best placed to address this point and provide further clarification.

We have responded to the aspects relating to Sussex Medical Chambers (SMC). As detailed in response to concern 1, the findings from our November 2022 inspection have already been addressed and are therefore not repeated here.

In response to the Regulation 28 report and as part of our regulatory response, we asked Sussex Medical Chambers (SMC) to tell us how they have responded to this aspect of the Regulation 28 report.

SMC informed us that [redacted] did not unilaterally investigate Mr Hankin's death. The circumstances of Mr Hankin's death were reviewed at a clinical governance meeting on 1 November 2023 by the service director, 2 operations managers, the managing director, [redacted] and a consultant in renal medicine from University Hospitals Sussex NHS Foundation Trust. At this meeting, the circumstances preceding Mr Hankin's death were formally examined. SMC acknowledged that Goring Hall Hospital (GHH) was undertaking its own investigation into Mr Hankin's care and, in accordance with established protocol for cases involving multiple healthcare providers, SMC reached out to the hospital to offer input into their review.

They told us that they have reviewed Mr Hankin's care more recently while responding to requests for information for the inquest. We understand they also requested a recording of the 4-day inquest along with Goring Hall Hospital's serious incident review to support further learning and reflection.

SMC told us that [redacted] has self-referred to the GMC and SMC has appointed a consultant urologist as Interim Clinical Governance Lead for the CUS until the GMC has concluded its inquiry. [redacted] will be subject to monthly supervision sessions with the Interim Clinical Governance Lead while the GMC investigation is ongoing.

They informed us that they have developed a Communication Improvement Plan specifically to address the concerns around referral pathways and siloed working. The plan establishes a formal process for following up clinical incidents in collaboration with other agencies and includes a Referral Risk Assessment Checklist to ensure patients are referred to the appropriate secondary care provider.

In addition, SMC has implemented a Managing Clinical Incidents Plan, which includes measures to reinforce existing policies, strengthen incident review processes, and promote confidence and learning among staff.

We reviewed both documents and were satisfied that these actions demonstrate a clear commitment to improving referral processes, communication, and the management of clinical incidents.

6. Management of Mr Hankin at Goring Hall Hospital.

There were multiple omissions in the pre-operative, intra-operative and post operative care provided by Goring Hall Hospital which individually and collectively contributed to Mr Hankin's death. This included a failure to recognise Mr Hankin underlying medical co-morbidities rendered him unfit to have his operative procedure at the hospital. More specifically the post-operative assessment and support provided by the consultant anaesthetist and surgeon led to a delay in assessing and diagnosing sepsis and thereafter giving appropriate and timely antibiotics and facilitating an earlier transfer to the NHS Hospital for further management. This gives rise to a concern that there was a lack of understanding by the senior clinicians (in the absence of any local and national guidelines provided at the inquest) requiring them to remain responsible for the care of patients throughout their time in a private

hospital rather than delegating the care to a Resident Medical Officer who is more likely than not to be insufficiently experienced in managing such critical situations.

We have responded to the concerns relating to Goring Hall Hospital.

On 11 September 2023, Goring Hall Hospital submitted a statutory notification to the Care Quality Commission (CQC) reporting the death of Mr Hankin.

As the independent regulator of health and social care services in England, the Care Quality Commission (CQC) reviewed the circumstances surrounding Mr Hankin's death in line with our statutory responsibilities. Our inspection team engaged with the provider, to understand the actions taken in response to the incident and to assess whether there were any breaches of fundamental standards or regulatory requirements.

On 12 September, we requested further information from the provider, including investigation plans, immediate actions and the final investigation report, once available. By 14 September, the registered manager confirmed that a patient safety incident investigation (PSII) had commenced. No immediate actions had been implemented at that stage, but communication with the patient's family and NHS trust was ongoing.

We continued to monitor progress and followed up on 22 January 2024 for an update. On 23 January, the provider reported that the draft patient safety incident investigation (PSII) had been completed and was under review by the Corporate Governance team. On 29 April, we formally requested the PSII, and the provider shared the final draft of the patient safety incident investigation report. The provider confirmed that the report had been shared with the patient's family and the coroner, and that an inquest date was pending.

On 1 May 2024, we reviewed the patient safety incident investigation (PSII) report in line with CQC's Specific Incident guidelines.

Under this guidance, Inspectors, supported by Operations Managers, undertake an initial assessment of specific incidents where there is reasonable suspicion that people using a regulated service have sustained avoidable harm or been exposed to a significant risk of avoidable harm. Two important questions are answered as part of the initial assessment.

1. Does the information about the specific incident raise concerns about ongoing risk of harm to users of the service which CQC should inspect?
2. Does the information about the specific incident suggest the harm sustained was avoidable and may have resulted from a registered person (Provider or Registered Manager) breach of a prosecutable fundamental standard? For example, a breach of Regulation 12(1) failure to provide safe care and treatment? If so, CQC should gather further evidence about the incident as part of a formal criminal investigation once that decision has been validated by CQC National Criminal Case Assessment and Progression Panel (CCAPP).

We addressed question 1. We reviewed the provider's investigation and action plan to assess the ongoing risk of harm and determined that the provider's action plan was appropriate and proportionate to address the identified concerns.

The provider's action plan focused on strengthening pre-operative assessment and patient safety through measures such as auditing referral quality, revising admission information and health questionnaires, and introducing processes to validate patient data. A shared care record was implemented to improve access to linked NHS data, and admission criteria were

updated to include neutrophil thresholds. Point-of-Care Testing enabled rapid blood results, while consultant expectations were aligned for same-day reviews.

Additional initiatives included a pre-assessment outcome tracker, reassessment of Registered Nurse (RN) competency in National Early Warning Score (NEWS2), integration of the Sepsis 6 pathway and scenarios into Critical Care Development Programme (CCDP) training, revisions to the anaesthetic chart, and a new checklist for reviewing and escalating blood results.

We went on to address question 2. We noted a delay in the administration of IV antibiotics for suspected sepsis, which were delivered 55 minutes beyond the recommended one-hour window. However, records indicated that staff were engaged in other diagnostic procedures at the time, and training documentation confirmed familiarity with the Sepsis 6 protocol.

We also examined concerns regarding the pre-operative assessment, where certain chronic health conditions had not been documented. The provider acknowledged this oversight and subsequently revised its assessment process. The consultant confirmed that these omissions would not have influenced the decision to proceed with surgery, given the patient's ongoing risk of urinary tract infections.

Based on the information available at the time, we concluded that the shortfalls were individual, rather than provider failings and that the incident did not meet the threshold for classification as a Specific Incident in line with CQC's Specific Incident guidelines.

CQC's prosecutorial powers only extend to registered persons. A registered person means either the provider or their registered manager. Failures by individuals are not within our remit; therefore, we cannot pursue this matter any further.

Since receiving the Regulation 28 Report, we have reflected on our regulatory response and have acknowledged that while the majority of actions had already been completed, we did not follow up with Goring Hall Hospital (GHH) to confirm full implementation of their actions. We have since asked GHH for their updated action plan to ensure full implementation.

In addition, CQC have taken steps to strengthen support for inspection teams to ensure the Specific Incident process is consistently followed in future cases in line with CQC's Specific Incident guidelines. To enhance our oversight of Specific Incidents, we have established a Specific Incident Progression Team. This team supports inspection staff in meeting our responsibilities for incident follow-up and ensures alignment with our enforcement powers. As you may be aware, since 1 April 2015, the Commission has held responsibility for prosecuting registered persons for failures to provide safe care and treatment where service users have been exposed to or sustained avoidable harm, under Regulations 12(1) and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to the Regulation 28 report and as part of our regulatory response, we asked Goring Hall Hospital (GHH) to tell us how they have responded to this element of the Regulation 28 report.

GHH clarified that as with all CHG sites, they operate a consultant-led care model, which is adopted across the independent sector. Consultants' responsibilities are clearly and robustly identified in CHG's practising privileges policy, which draws upon GMC's Good Medical Practice and associated national guidance. The responsibilities are also made clear in other policies, including CHG's Care of the Deteriorating Patient policy which explicitly sets out the expectations of both consultants and Resident Medical Officer (RMO) when managing patient deterioration and is entirely clear that consultants remain responsible for clinical care

through a patient's stay in a CHG hospital. Furthermore, it mandates that a failure of a consultant to respond in line with their responsibilities must be escalated to the senior management team. It also makes explicitly clear the RMO responsibility and training and competence expectations.

GHH clarified that consultant compliance with their responsibilities is monitored and ensured through a combination of incident reporting and monitoring, appraisal, biennial review, audit and Freedom to Speak Up. Any concerns about a consultants performance are addressed under CHG's Responding to Concerns about Medical Practitioners policy.

CHG ensures that policies are regularly reviewed under its medical governance framework to remain in-keeping with best practice. Having considered the coroner's concerns carefully, CHG was satisfied that no additions or changes to its current processes and policies were required.

We have reviewed CHG's Care of the Deteriorating Patient policy (CHG NURpol33) and CHG's Responding to Concerns about Medical Practitioners policy (CHG GOVpol35) and consider these to be clear and based on national guidance.

We asked Goring Hall Hospital (GHH) for their updated investigation and action plan to ensure full implementation and have reviewed this.

They told us that following the inquest findings, they reviewed their original action plan and undertook a comprehensive gap analysis between their initial findings and the coroner's conclusions, which were issued nearly two years later. All of their original actions had been implemented as were the majority of their additional actions.

As part of additional measures, the provider shared the coroner's findings with governance committees and involved consultants, introduced documentation for recording antimicrobials during pre-operative optimisation, and updated patient materials to confirm medication changes.

Consultant responsibilities for optimisation were clarified through reflection and shared learning sessions. A digital report summarising procedures and pre-assessment outcomes was implemented, alongside annual audits of NEWS2 accuracy and quarterly scenario assessments for deteriorating patients.

Training was strengthened by reviewing escalation protocols and adding sepsis scenarios, while daily Medical Emergency Team (MET) meetings and ward rounds were established to monitor high NEWS2 scores. The clinical escalation SOP was promoted in line with the "Call to Concern" initiative (Martha's Rule).

I trust that the considered response provided, alongside the actions undertaken by the Care Quality Commission, offers the necessary assurance in accordance with our regulatory responsibilities. We will continue to monitor the provider's compliance with regulatory standards and ensure that learning from this case is embedded into practice. We remain committed to supporting improvements in patient safety and care quality across all services.

Yours sincerely,

[redacted]

[redacted]

Interim Deputy Director