

**Mr Andrew Walker**  
Senior Coroner for North London  
Barnet Coroner's Court  
29 Wood Street  
Barnet  
EN5 4BE

**Co-National Medical Director**  
NHS England  
Wellington House  
133-155 Waterloo Road  
London  
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8 April 2026

Dear Coroner,

**Re: Regulation 28 Report to Prevent Future Deaths – Jacqueline Aarons who died on 19 November 2024.**

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 13 November 2025 concerning the death of Jacqueline Aarons on 19 November 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Jacqueline's family and loved ones. NHS England are keen to assure the family and yourself that the concerns raised about Jacqueline care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused to Jacqueline's family or friends. I realise that responses to Coroners' Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones, and I appreciate this will have been an incredibly difficult time for them.

Your report raised concerns around the following:

1. The need for recognised lower thresholds for hospital admission for patients with learning disability
2. The need for face-to-face consultations by a doctor
3. Following any consultation, there should be written instructions including safety netting advice, set out in such a way that they may be understood and acted upon by staff who may not be medically trained.

**Recognised lower thresholds for hospital admission for patients with a learning disability**

It is recognised that people with a learning disability experience significant health inequality, including diagnostic overshadowing and reduced life expectancy. They do not always express symptoms of pain or disease in ways similar to other people because of challenges in communication or understanding of physical signs affecting their body. They may not act upon discomfort, pain, or distress. This is more likely in autistic people with or without a learning disability. Family and paid carers may not be aware of the subtle signs of distress in the person with a learning disability.

The use of the Modified Early Warning Score (MEWS) can support earlier identification of clinical deterioration by providing an objective measure of physiological change. While MEWS is not a substitute for clinical judgement, it can act as an important adjunct in decision making for people with a learning disability, particularly where communication difficulties or atypical presentations may mask severity of illness.

This approach is consistent with [Learning from Lives and Deaths – People with a Learning Disability and Autistic People](#) (LeDeR), which highlights the need for earlier recognition, timely escalation, and proactive responses to physical health concerns to reduce avoidable deaths and health inequalities.

For these reasons, a lower threshold for clinical assessment in hospital is warranted. In addition, expert clinical input from a Learning Disability Physician would assist front-line clinicians in formulating care plans for the people with learning disability and Autistic people.

### **Face to face consultation by a doctor**

The importance of face-to-face clinical assessment by a doctor is acknowledged for people with a learning disability where there are concerns about deterioration, uncertainty in presentation, or escalation of risk.

Given the known challenges of diagnostic overshadowing and atypical symptom presentation, in person consultation allows for a more comprehensive assessment, including physical examination, observation, and holistic consideration of the individual's baseline functioning. This is particularly important where remote consultation may limit accurate assessment or where nonverbal indicators of distress or illness may be present.

This approach supports safer clinical decision making and reflects best practice in delivering reasonable adjustments to ensure equitable access to healthcare.

### **Written instructions and safety netting advice following consultation**

Following any consultation, clear written instructions and safety netting advice should be provided. These instructions must be set out in a way that can be understood and acted upon by staff who may not be medically trained, including carers, support workers, and residential staff.

Written guidance should:

- Clearly describe what symptoms or changes to look out for
- Specify when and how to seek urgent medical help
- Use plain language and avoid unnecessary medical terminology
- Be tailored to the individual's communication needs and level of understanding
- Be copied to the person's GP

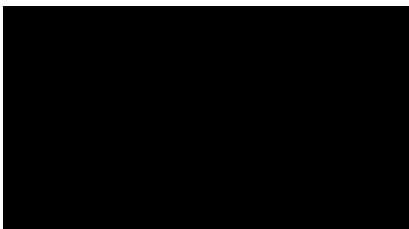
This is essential to ensure continuity of care, reduced reliance on verbal recall, and to support timely escalation if the person's condition worsens.

Workforce capability in this area is supported through initiatives such as the [Oliver McGowan Mandatory Training](#), which aims to improve staff knowledge, skills, and confidence in providing safe, compassionate, and appropriately adjusted care for people with a learning disability and autistic people. The functions of the Learning Disability Physician and Liaison Nurse in Learning Disability support enhanced clinical practice of front-line clinical staff in hospital services and in primary care services.

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 Jacqueline 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