**Mr Zafar Siddique**
Senior Coroner for the Black Country
The Coroner's Court
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Halesowen Street
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B69 2AJ

By Email: [redacted]

**National Medical Director**
NHS England
Wellington House
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[redacted]

9 April 2026

Dear Coroner,

**Re: Regulation 28 Report to Prevent Future Deaths – Stephen Martin Rhodes who died on 11 March 2025.**

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 6th February 2026 concerning the death of Stephen Martin Rhodes on 11th March 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mr Rhode's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Mr Rhode's care have been listened to and reflected upon.

Your Report raised concerns that laboratory reports don't flag or highlight an abnormal blood result on the front page of the report. You advised that NHS England may wish to review any national guidance on how abnormal results are flagged by laboratories.

The responsibility for the formatting, structure and presentation of pathology results sits primarily with:

- The laboratory information management system (LIMS) supplier, and
- The GP clinical system supplier, who determines how results are displayed once the results have been received

NHS England's role has been to set out a range of interoperability standards. The current standard that guides how the flow of information passes between the pathology report laboratory and the receiving GP practice is the called the 'Pathology Messaging Implementation Project - Electronic Data Interchange for Administration, Commerce and Transport (PMIP EDIFACT) Standard.

If a laboratory test result falls outside the normal range, the PMIP EDIFACT pathology report includes a marker in most cases to show this. GP records system providers can use this marker to alert the receiving GP that the result is abnormal or different from the expected range. This marker is called the 'Deviating Results Indicator.' It is the responsibility of the GP system provider to ensure this information is clearly displayed

and thus properly received to the GP. We note that you have indicated the supplier in this case has already responded to the need for greater visibility of abnormal results.

EDIFACT is a legacy product, and NHS England is currently promoting the adoption of a new nationally agreed Pathology Messaging Standards using Fast Healthcare Interoperability Resources (FHIR). The new system will:

- Allow results to be sent in a structured way to GPs so their computer systems can read them more easily which reduces the risk of mistakes and helps ensure nothing important is missed.
- Enable standard clinical coding system called SNOMED CT to be used, which helps ensure test names and results mean the same thing everywhere and to every practice. This improves communication between laboratories, hospitals, and GP practices.
- Ensure results are sent using a secure NHS messaging system which helps keep personal medical information safe.
- These changes will initially cover common tests such as blood counts, biochemistry (like kidney or liver tests), immunology, and microbiology (infection tests) but will widen its scope over time.

NHS England's Pathology FHIR Specification is one of the data products mandated for use in the DAPB4101: Pathology and Laboratory Medicine Reporting Information Standard. The Information Standards Notice (Amd 63/2023) that supports DAPB4101 was issued on 15th April 2024.

The Pathology Transformation and Interoperability Programme in NHS England is currently undertaking the opportunity to promote:

- Wider standardisation of pathology result flagging conventions
- Strengthen digital clinical safety assurance across Laboratory Information Management System and primary care systems

To help providers and system suppliers integrate the Pathology FHIR Specification and reach conformance with DAPB4101, four NHS England teams (Core Services, Digital Services for Integrated Care, Diagnostic Digital Capability, and Terminology Design) are working together to create a roadmap for national adoption.

A pilot is underway to establish and prove how a DAPB4101 pathology report can be sent from labs and ingested by GP practices safely. This will involve working with the GP system supplier, and the three pathology middleware suppliers that enable national coverage for lab to GP reporting as well as with Berkshire & Surrey NHS Pathology Services. Once the pilot has completed, implementing DAPB4101will then go onto NHS England's GP system suppliers' managed roadmap of development work, leading to national roll-out.

**GP Practice Systems and Result Handling Processes**

Your report notes that the practice handles 'several hundred' reports per day.

NHS England recognises the need for robust result review processes are needed at pace in busy practices and the ability to correctly assign and act on results.

While operational arrangements are managed at individual practice level, NHS England has published several resources available to support safe systems of work, including:

- Clinical messaging and test results. This guidance is part of the Data sharing and interoperability section of the Good practice guidelines for GP electronic patient records.

- Use of clinical decision support NHS England » Supporting clinical decisions with health information technology

- Digital clinical safety standards (DCB0129/DCB0160)

All of which support safer practice.

**Auto reviewing of pathology results**

Some GP practices employ third-party software solutions that use Robotic Process Automation (RPA) to support or automate the handling of both normal and abnormal laboratory results. These RPA tools operate outside of the digital safety assurance work undertaken by NHS England. Some of the major GP records suppliers have introduced significant robotic automation capabilities for laboratory tests within their electronic patient record systems which have been specifically designed to reduce the administrative burden on GPs and improve patient safety. This system, often referred to as "auto-reviewing" or "Pathology Auto-review" automatically processes, files, and, in some cases, manages the follow-up of test results. Auto-review and auto-filing of pathology results in GP systems can only ever be safe if “normal” is interpreted in the context of the individual patient, not just the laboratory reference range, so these functions need stringent governance, testing, feedback, and monitoring.

Other Guidance includes:

- GP mythbuster 46: Managing test results and clinical correspondence - Care Quality Commission which informs practices on how they should manage test results and clinical correspondence and
- The General Medical Council Good Medical Practice 2024 establishes the professional duties that underpin safe test result handling, including providing a good standard of care, ensuring continuity, and acting on info

Patient safety is at the heart of NHS England’s role and the 2024 ‘Primary Care Patient Safety Strategy’ describes some of the work and approaches being promoted by NHSE. The Patient Safety Team (clinician’s) and technology teams work in step with one another to support patient safety related to digital systems and technology clinical assurance processes.

NHS England’s Patient Safety teams and Digital Clinical Safety team have a programme of work that monitors reported clinical incidents via the Learning From

Patient Safety Events (LFPSE) portal which receives incidents reported by all clinical organisations funded by the NHS. This activity includes looking for any emerging trends and includes a review of all PFD reports to ensure that any lessons learned from incidents are discussed and fed into future national policy on patient safety. Learning may be shared via specific advice given, incorporated into training sessions or documented guidance or policy. Learning is shared with suppliers, technologists and Digital Clinical Safety Officers in line with DCB standards which help ensure digital health products are safe and help to reduce harm events and in line with the Patient Safety Strategy.

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 Mr Rhodes 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]

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National Medical Director
NHS England