Mr Andrew Walker
HM Senior Coroner
Barnet Coroner's Court
29 Wood Street
Barnet
EN5 4BE

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

[redacted]

6 July 2026

[redacted]

Dear Mr Walker,

Re: Regulation 28 Report to Prevent Future Deaths – Albert Thomas Bellingham who died on 10 November 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 12 March 2026 concerning the death of Albert Thomas Bellingham on 10 November 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mr Bellingham's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Mr Bellingham's care have been listened to and reflected upon.

Your Report advises that you are concerned that "*consideration of guidance to support to interventionalist, supervisory roles, with appropriate training for doctors working in care home when dealing with pressure sores.*"

Nursing

National nursing colleagues have advised that pressure ulcers and those specifically of the nature highlighted in this case are often driven by a range of complex interactions. These include the characteristics of the patient including their physiological decline, as well as organisational care failures, localised mechanical forces such as beds and chairs, and other related contributory and system factors. This means that an understanding of the multifactorial risks and wider system issues is needed, before effective interventions can be identified and given, to address those gaps in care delivery, and prevent, manage and treat pressure ulcers.

There is currently no single, unified, accessible guidance document specifically addressed to doctors working in care home settings, that sets out the expected supervisory and interventionalist role in relation to pressure ulcers. However, NICE Clinical Guideline CG179 'Pressure ulcers: prevention and management' (2014, last updated in 2024) provides the primary national clinical framework for the prevention and management of pressure ulcers across all healthcare and social care settings, including care homes. The guideline applies to all registered professionals involved in patient care, including doctors, and covers:

- Risk assessment using validated tools (such as the Waterlow scale) for all patients admitted to a care setting, with particular attention to those with reduced mobility, poor nutrition, or existing skin fragility.
- Regular repositioning and use of pressure-redistributing equipment (mattresses and cushions) for those identified as at risk.
- Skin inspection and monitoring, with documentation of any changes.
- Escalation to appropriate clinical staff when pressure ulcers are identified, with prompt initiation of a care plan.
- Clear documentation of pressure ulcer category (using the validated four category classification system) and wound dimensions.

NICE Quality Standard QS89 'Pressure Ulcers' (2015) also sets out a measurable statement of best practice applicable across all care settings and is the basis for assessing provider performance. Quality statements include the expectation that people in care settings are assessed for pressure ulcer risk on admission and that those at risk receive personalised prevention plans.

The NHS England commissioned National Wound Care Strategy Programme (NWSCP) developed and published evidence-informed recommendations for pressure ulcer care across all health and care settings – Pressure Ulcer Clinical Recommendations and Clinical Pathway (2023/24):

- The NWCSP's work recognises care homes as a key setting where pressure ulcer harm occurs, and the programme engaged with care home providers in its implementation sites.
- The recommendations include use of the aSSKINg framework (Assess risk, Skin assessment and skin care, Surface selection and use, Keep moving, Incontinence and moisture, Nutrition and hydration, Giving information) for individualised structured assessment and prevention planning, and to provide clear pathways for escalation when pressure damage is identified or deteriorates.

Both the British Geriatrics Society and Royal College of General Practitioners provide guidance and continuing professional development resources relevant to the care of frail older adults in care settings, including the management of skin integrity and complex wound care needs.

General Practitioners (GPs)

GPs play an important role in the care of people living in care homes, providing medical care, clinical leadership and oversight as part of a multidisciplinary approach to meeting residents' needs. Under the Enhanced Health in Care Homes model, care is delivered collaboratively by primary care, community nursing, care home staff and other health and care professionals, with residents supported through comprehensive assessment, personalised care planning and regular multidisciplinary review.

The direct assessment and treatment of pressure ulcers, including routine wound care and dressing management, would ordinarily fall within the professional responsibilities of appropriately trained nursing staff and other relevant clinicians. GPs are not generally responsible for the delivery or supervision of routine dressing care; however, they remain responsible for providing medical care to their patients and may contribute to the assessment, management and escalation of the resident's underlying clinical condition where clinically appropriate.

Infection prevention and control

National Infection Prevention and Control Team have advised that Entercloser Boltae bacteraemia, suffered by Mr Bellingham, is a rarely identified anaerobic organism previously classified within the clostridium genus. Positive blood cultures involving this bacterium appear to be exceptionally uncommon, although its identification does not exclude the possibility of clinically significant bacteraemia.

The documentation provided contains limited detail regarding the sacral sore/ulcer and does not include microbiological findings from wound swabs, tissue samples or other investigations relating to the affected area. In the absence of this information, it is difficult to determine the source, extent, or progression of any infection with certainty.

It is clinically plausible that the sacral lesion may have been contaminated with faecal material, potentially resulting in a localised soft tissue infection which may have progressed more deeply and contributed to bacteraemia. However, given the rarity of the organism identified in the blood cultures, together with the limited clinical and microbiological information available, it is not possible to draw definitive conclusions regarding the sequence of events or source of infection in this case.

More generally, the assessment and recognition of infection forms part of routine clinical assessment and decision-making. Medical staff are expected to assess patients for signs of infection as part of ongoing clinical review, including consideration of potential infection sources, interpretation of clinical observations and investigation results, and referral for specialist advice where appropriate. This approach is reflected within General Medical Council (GMC) Good Medical Practice 2024 and NICE Guideline NG51 and NICE Guideline NG253: Suspected sepsis in people aged 16 or over: recognition, assessment and early management.

The NHS recognises the importance of ensuring that healthcare professionals are appropriately trained, supported and clinically supervised when managing patients at risk of, or presenting with, pressure ulcers. Pressure ulcer prevention and management remain important patient safety priorities across health and social care settings due to their association with avoidable harm, infection risk, clinical deterioration, and safeguarding concerns.

National guidance is available through the National Wound Care Strategy Programme, NICE and NHS England, which collectively promote evidence-based approached to pressure ulcer prevention, wound assessment, infection prevention and control (IPC), escalation pathways, and multidisciplinary care delivery.

Doctors entering NHS practice receive education and training through undergraduate medical curricula, postgraduate training programmes, mandatory NHS training requirements, and continuing professional development. This includes training in:

- Infection prevention and control (IPC)
- Safeguarding vulnerable adults
- Recognition and management of deteriorating patients
- Pressure ulcer prevention and assessment
- Antimicrobial stewardship
- Clinical governance and patient safety

The NHS continues to work with partner organisations to strengthen workforce capability. NHS organisations are expected to provide local induction, competency-based education, and access to specialist support, including tissue viability and infection prevention teams, for clinicians working in community and care home settings.

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 Bellingham, 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