

Mr James Bennett
Assistant Coroner
Birmingham and Solihull
The Birmingham and Solihull Coroner's Court
Steelhouse Lane
Birmingham
B4 6BJ

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

[REDACTED]
8 June 2026

Dear Mr Bennett,

**Re: Regulation 28 Report to Prevent Future Deaths – [REDACTED]
who died on 8 October 2025.**

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 29 April 2026 concerning the death of [REDACTED] on 8 October 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to [REDACTED] family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about [REDACTED] care have been listened to and reflected upon.

NHS England takes the sexual safety of staff and patients very seriously and we have produced a comprehensive suite of documents to ensure that NHS employers are taking their legal responsibilities around sexual harassment prevention seriously. These include:

- The [Sexual Safety Charter](#) – an aspirational set of principles that all NHS trusts and ICBs have signed up to;
- The [national sexual misconduct policy framework](#) – an adaptable framework for trusts and ICBs to use to develop their own local sexual misconduct policies;
- [Understanding sexual misconduct in the workplace](#) – base level training for all employees to be aware of issues surrounding sexual misconduct, disclosures and appropriate behaviours.

Your Report raised concerns about whether these documents are clear enough about how to support employees who are perpetrators or alleged perpetrators of sexual harassment in the NHS.

We take support for all those involved in these processes very seriously. Organisational support for these individuals is contained within the national policy framework which makes clear that support should be provided to all involved. This is done in several places within the framework:

- Under the review group section of the policy framework, it is recommended that organisations set up review groups for specially reviewing any case with a sexual component. In this section, we make clear that a risk assessment should

be done for all those involved which should include assessment of possible harm and where police should be contacted.

- The associated review group checklist is clear that support should be offered to all those involved and a risk assessment should be contact to support wellbeing and to reduce any further harm.
- The responsibilities for HR teams includes making clear that HR should offer support to everyone involved in a report.

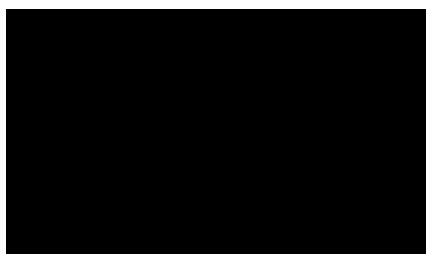
The [national sexual misconduct policy framework](#) makes clear that risks to individuals should be immediately assessed and steps should be taken once an allegation is reported. Steps such as suspension or removing access to fatal drugs should be considered, but these actions would not be governed specifically by a sexual misconduct policy. These decisions would typically be governed by policies relating to managing conduct (disciplinary), competence, professional standards regulations or medications management.

NHS England are also taking further steps to ensure that harm arising from going through the process of an employee relations case is mitigated. We are currently reviewing the investigations training offered to every trust HR team in the country, which has a significant focus on sexual misconduct clear sections on how to reduce harm from these processes for all parties. We are also developing a national conduct and competence policy framework which will have key sections on planning support for those involved in the process and risk assessment.

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 [REDACTED], 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