Mrs Dianne Hocking
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Leicester
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[redacted]

National Medical Director
NHS England
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4th September 2026

Dear Mrs Hocking,

Re: Regulation 28 Report to Prevent Future Deaths – Malcolm Ian Budd who died on 24th February 2026.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 21st July 2026 concerning the death of Malcolm Ian Budd on 24th February 2026. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mr Budd's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Mr Budd's care have been listened to and reflected upon.

Your Report raised concerns that the Acute Aortic Dissection Pathway Toolkit ("Toolkit") has not been implemented in East Midlands. There is intention to facilitate the development of a regional Standard Operating Procedure (SOP) but to date this has not been formally implemented.

We have liaised with the NHS England Midlands Regional Team about your concerns. They have advised that the provision of Cardiac Surgery Services, including emergency surgery for aortic dissection, are commissioned and overseen regionally by NHS England Specialised Commissioning Team, with collaborative working with the relevant Integrated Care Boards.

The Regional Specialised Commissioning Team is working closely and co-ordinating with relevant acute providers (namely Nottingham University Hospitals NHS Foundation Trust and University Hospitals Leicester (Glenfield) in the East Midlands to establish agreed pathways that fulfils the requirements of the Acute Aortic Dissection Pathway and includes a single point of contact for referring centres in the East Midlands, with the intention of improving transfer times for patients requiring time-critical emergency surgery at a specialist site.

The Regional Specialised Commissioning Team are confident this will be achieved and a "Go Live" date achieved for the East Midlands by Autumn/ Winter 2026.

This Toolkit is relevant from the point of diagnosis of aortic dissection, specifically with difficulties in managing emergency acute aortic dissection. For best practice on investigation, diagnosis and decision-making, the royal college provides best practice

guidelines for emergency department diagnosis of thoracic aortic dissection. Diagnosis of thoracic aortic dissection in the emergency department | The Royal College of Radiologists. Based on the information in your Report, it appears there was approximately 5.5 hours between when Mr Budd was admitted to Royal Derby Hospital and when diagnosis of aortic dissection was confirmed. This timing would precede the implementation of the Toolkit. Adult Critical Care Co-Ordination and Transfer Service (ACCOTS) were then engaged, which affected transfer within time critical timetables, meeting the criteria for Principle 5 (Safe Transfer) of the Toolkit.

NHS England is not party to the inquest, which is yet to conclude and does not have access to case-specific information while Mr Budd was at Royal Derby Hospital. NHS England therefore does not have any details or circumstances beyond those shared in your report and cannot comment on the quality of monitoring and observation and senior clinical oversight of Mr Budd while at the referring centre.

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 Budd, 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 Director of Patient Safety
NHS England