

Safe in their hands? The government's response to coroners' warnings about the NHS

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Summary

How diligently does the government protect the public from risks?

This is a follow up paper about the system response to coroners' Section 28 warning reports on Action to Prevent Future Deaths, and how the NHS in particular responds risks to public safety.

The overall picture at the top of the NHS is one of defensiveness, half-answered questions and some conflicting accounts from different bodies, or even from the same body. It is very unclear to what extent the audit cycle is safely closed after coroners raise a concern.

If that is the example set at the top, this raises concerns about governance through the system.

Since 2013, coroners in England and Wales have been under a duty to issue a Section 28 report on action to prevent future deaths (also known as PFD reports) if they find risk factors that pose a threat to life.

Parties who receive a Section 28 report must provide a written response within 56 days.

By law, Coroners are required to send their report and any responses to the Chief Coroner.

Coroners and Justice Act 2009

"Schedule 5 Powers of Coroners

Action to prevent other deaths 7 (1) Where— (a) a senior coroner has been conducting an investigation under this Part into a person's death, (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action. (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it. (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner."

http://www.legislation.gov.uk/ukpga/2009/25/pdfs/ukpga_20090025_en.pdf

The Chief Coroner has discretion to publish the reports and corresponding responses, or not:

The Coroners (Investigations) Regulations 2013

“PART 7

28. (5) On receipt of a report the Chief Coroner may—

(a) publish a copy of the report, or a summary of it, in such manner as the Chief Coroner thinks fit; and

(b) send a copy of the report to any person who the Chief Coroner believes may find it useful or of interest.”

<http://www.legislation.gov.uk/uksi/2013/1629/part/7/made>

The Chief Coroner has advised in his 2016/17 annual report that in 2016, 46% (241,211 of 524, 723) of registered deaths were referred to coroners. 40,504 of these cases that were reported to coroners were deemed to need investigation and inquest.

Section 28 reports are exceptionally issued and represent very significant concern by coroners. The Chief Coroner advised that between June 2016 and July 2017, 375 Section 28 reports were issued. My enquiries and other data have shown that whilst an NHS trust may have hundreds of inquests, they may typically be issued only a handful of Section 28 reports.

The coronial system relies on reporting but is hampered by failures of reporting. This context increases the significance of Section 28 reports.

Earlier this year, I analysed four years of data published by the Chief Coroner and found that there were no published responses to 62% of the Section 28 reports on the Chief Coroner’s website.

Four years of published coroners’ Section 28 reports in England and Wales, 24 August 2017

<https://minhalexander.com/2017/08/24/four-years-of-published-coroners-section-28-reports-in-england-and-wales/>

In some cases, this has since proved to be because respondents had failed to comply with Section 28 notices. For example, the government failed to respond to a coroner’s 2015, pre-Grenfell warning about the need for sprinklers in housing stock, especially for vulnerable residents. It only replied to the coroner in December 2017, after an enquiry about its missing response:

<https://www.judiciary.gov.uk/publications/emma-waring/>

<https://minhalexander.files.wordpress.com/2018/01/171214-dclg-response-to-coroner-waring175602.pdf>

My search of the Chief Coroner's website was laborious as the website has minimal search capability, and Section 28 data has to be manually sifted.

I also found no published evidence of corresponding central analysis by the NHS of Section 28, from the Department of Health and Social Care downwards.

Subsequent enquiries to the Chief Coroner's office and the Department of Health and Social Care and other central NHS bodies revealed some conflicting statements about whether responses to Section 28 reports had been withheld from publication by the Chief Coroner.

CQC claimed that it had asked for some its responses to Section 28 reports to be withheld from publication by the Chief Coroner. The Chief Coroner advised that his office had not received any such requests. In the face of this information from the Chief Coroner, the CQC indicated that it did not contest the Chief Coroner's account of events.

There also appeared to be variance between some coroners and the Chief Coroner's office. The Chief Coroner advised that he published all or most of the material received from coroners.

A sample of 21 coroners reported that they had submitted all Section 28 reports and related responses to the Chief Coroner. However, the Chief Coroner's website showed a total of 342 Section 28 reports from these 21 coroners over a four year period, for which there were published responses in only 128 (37%) cases.

Similarly, information from some test enquiries to trusts also suggested not all Section 28 reports that are issued to trusts reach the Chief Coroner's website. The Chief Coroner was alerted to this.

Nonetheless, the Chief Coroner has now committed in principle to full publication of all Section 28 reports and related responses.

There is no apparent system for ensuring compliance by coroners and the Chief Coroner has stated that he merely encourages coroners to write and submit reports when appropriate.

With regards to government learning from the Section 28 data, there appears to have been a change of policy in that the Chief Coroner's office stopped producing regular trends analysis of Section 28 reports after September 2013. The office also advised that it was not sufficiently resourced to make improvements to its public facing database, to give the public greater access.

With regards to the NHS, there was limited evidence of systematic analysis and learning, with only relatively recent attempts to track and analyse trends shown by Section 28 reports. Moreover, the learning from thematic analyses has not been shared with service providers or the public.

There was reluctance by CQC to disclose analyses that it had undertaken, with initial claims that these were exempt from disclosure that were eventually waived.

The Department of Health and Social Care (DHSC) showed the greatest resistance to learning. It essentially claimed that analyses of Section 28 data were not worthwhile because the data is insufficiently standardised. This is difficult to square with its arms length bodies' differing approaches and commitment to better future analysis of this data. Indeed, NHS England considered coroners' Section 28 reports to be a 'reliable' source of data.

There was also no evidence that the arms length bodies are working together to reliably share information on Section 28 reports. NHS Improvement advised that it relies on trusts to notify it of Section 28 reports, when it could in fact make use of routine notifications by coroners to the CQC.

The DHSC, NHS England, the CQC and NHS Improvement all refused to disclose copies of their responses to particularly significant Section 28 reports that had been missing from the Chief Coroner's website. NHS England, CQC and NHS Improvement relied on a past ICO decision that responses to coroners' Section 28 reports are court documents and exempt under Section 32 FOIA. This is despite the fact that the ICO has confirmed to me that there is nothing to stop these bodies from *voluntarily* disclosing their responses to coroners if they chose to do so:

“An organisation can choose to proactively publish information even if that information is exempt from disclosure under the Freedom of Information Act, or if the organisation is not subject to the Act.”

ICO Group Manager of FOI Appeals and Complaints Department 6 December 2017

The DHSC tried to wash its hands of responsibility by claiming that it was the Chief Coroner's responsibility to publish the documents, and stated that FOI exemptions would likely apply in any case.

This concerted opacity is a failure of leadership and accountability. It leaves major questions about under-resourcing of the NHS and systemic governance flaws unanswered. For example, whether national failings in managing ligature point risk have been addressed.

That said, although the CQC and NHS England refused to disclose key missing responses to some key Section 28 reports, some of the missing responses have now quietly appeared on the Chief Coroner's website.

For example, the CQC's previously missing 2014 response to a 2013 Section 29 report about national guidelines on night time staffing levels, which shows that CQC side-stepped the issue of committing to firm standards.

Another previously withheld but recently published CQC response to a high profile avoidable death at the private facility the London Bridge Hospital, rated 'Outstanding' by the CQC, reveals that the hospital initially informed the CQC that the death was 'expected'.

Overall, there needs to be a more proactive, joined up and transparent system response to coroners' Section 28 reports.

The government should ensure that all Section 28 reports and responses are published, and the NHS should adopt a policy of open reporting on Section 28 reports, responses and related analyses, subject to redaction of third party personal data where required.

The NHS should not be hiding behind FOI exemption, especially when the Chief Coroner has agreed that all Section 28 reports and responses should be published.

The Chief Coroner's office should also be adequately resourced so that it can once again report on a regular basis on national trends in Section 28 reports and maintain a database with sufficient functionality to allow meaningful, open access by the public.

I am passing my findings to the relevant parliamentary select committees.

I have also asked the Secretary of State for Health and Social Care to ensure disclosure at least of Section 28 report actions plans, in lieu of the responses to Section 28 reports that his department and its arms length bodies have refused to release. He has not yet responded at the time of writing.

Fuller details follow regarding data gathered about the Chief Coroner's office, the DHSC, NHS England, the CQC, NHS Improvement and background information from NHS trusts and coroners. Supporting correspondence and disclosed documents are provided.

Chief Coroner

The Chief Coroner acknowledges the importance of Section 28 reports:

"These reports are important. Coroners have a duty not just to decide how somebody came by their death but also, where appropriate, to report about that death with a view to preventing future deaths. A bereaved family wants to be able to say: 'His death was tragic and terrible, but at least it shouldn't happen to somebody else.'

The importance of PFD reports is emphasised by their upgrading by Parliament from a rule (Rule 43 of the Coroners Rules 1984) to part of the 2009 Act (para.7, Schedule 5) and by changing the coroner's discretion to make a report to a duty to make a report where a concern is identified.”¹

In response to enquiries, the Chief Coroner initially advised:

- His office had published all Section 28 reports and responses since July 2013
- The current law provides no sanction when parties that are issued with Section 28 reports fail to respond
- It was beyond the resources of his office to make its Section 28 data properly searchable and so more accessible to the public
- His office did hold any unpublished analyses of Section 28 data.

With regards to the last point, the government used to issue 6 monthly reports on the precursor to Section 28 reports, Rule 43 reports, which gave broad patterns.

The previous Chief Coroner published a single analysis on Section 28 reports for the period April 2013 to September 2013², but he and the current Chief Coroner did not publish any subsequent analyses.

Put together, all this implies there has been a troubling change of policy, with no further analysis after September 2013.

This is at odds with the Chief Coroner's own guidance to coroners (written by the previous Chief Coroner). This indicates that the Chief Coroner's office should have regards to patterns that may arise from multiple Section 28 reports:

“56. It is implicit in the statutory framework that the Chief Coroner should have a role in taking some reports (and responses) further. Therefore from time to time the Chief Coroner makes an assessment of areas of concern, whether from single or multiple reports, and may advise action where appropriate. He may consult on areas of concern and where feasible recommend action, whether by way of advice to government or an organisation or individual or where necessary

¹ Chief Coroner's Guidance Note No 5, on Reports to Prevent Future Deaths, 16 July 2013
<https://www.judiciary.gov.uk/wp-content/uploads/2013/09/guidance-no-5-reports-to-prevent-future-deaths.pdf>

² Chief Coroner's Summary of Reports on Action to Prevent Future Deaths for the period 1 April 2013 to 30 September 2013
<https://minhalexander.files.wordpress.com/2016/09/april-2013-to-september-2013-summaryreportofpfdreportsapr-sep2013-10th.pdf>

by recommending a change in the law. These recommendations may also be published.”¹

Clearly, patterns can only be reliably detected if analysis is undertaken.

Although the Chief Coroner’s office informed me that it published all Section 28 reports and related responses, some anomalies arose. The CQC later told me that it had asked for some of its responses to be withheld from publication by the Chief Coroner. I also received information from NHS trusts which indicated that some Section 28 reports had been issued, but for whatever reason, had not been published by the Chief Coroner.

For example, the Chief Coroner published only two Section 28 reports between July 2013 and July 2013 relating to Oxford University Hospitals NHS Foundation Trust, but the trust informed me that it had received twelve Section 28 reports during that period.

In response to a further enquiry about these anomalies, the Chief Coroner’s office advised:

- Some Section 28 reports may not have been published due to error:

“We accept that there will be some isolated cases where a Prevention of Future Death report has been issued but not published on the judiciary website. However, this is merely down to administrative error, which we are fully committed to rectifying on an ongoing basis to ensure all issued reports and responses received are published on the judiciary website within a reasonable time frame.”

- The Chief Coroner’s office does not hold a central record of requests for responses to Section 28 to be withheld from publication
- Equally though, it was also stated that the Chief Coroner has received no requests not to publish responses to Section 28 reports

Questions that I put to the Chief Coroner’s office which have not been answered include:

- How many Section 28 reports had been *issued* by coroners since July 2013 and what proportion of these had been published on the chief coroner’s website? (The Chief Coroner’s office advised only of the number of Section 28 reports that it had *published*)
- Is there a process which applies when coroners are dissatisfied with the Section 28 reports that they receive?

However, the Chief Coroner advised that the role of the coroner with respect to Section 28 reports is “limited”, and his guidance to coroners does not feature any advice on what to do if responses to Section 28 reports are unsatisfactory. It seems likely then that there is no process for challenging unsatisfactory responses to Section 28 reports.

- Does the Chief Coroner’s office have a mechanism for ensuring and or supporting reliable submission of Section 28 reports and responses by coroners, and a good response rate by respondents to Section 28 reports?

However, in the Chief Coroner’s latest annual report published on 30 November 2017, it is stated: *“The Chief Coroner encourages all coroners to write and submit PFD [Section 28] reports where appropriate.”*

This is noteworthy because in his latest annual report, the Chief Coroner takes issue with the current guidance for doctors on when to refer deaths to coroners because they only provide encouragement. He states in his report:

*“The notes, therefore, do no more than encourage doctors to adopt the criteria for registrars and report any death which should be referred to the coroner by the registrar of births and deaths”.*³

If the Chief Coroner can see that encouragement alone is insufficient to ensure good governance in the proper handling of untoward deaths, he should surely apply this principle to the handling of Section 28 reports, which are all the more serious because risk to life has been detected after formal scrutiny.

After some test enquiries, 21 coroners’ offices told me that they sent *all* Section 28 reports and responses to the Chief Coroner.

³ Chief Coroner’s annual report 2016/17

“120. The notes for doctors attached to the Medical Certificate of Cause of Death state, under the heading When to Refer to the Coroner: ‘There is no statutory duty to report any death to a coroner.’ The notes, therefore, do no more than encourage doctors to adopt the criteria for registrars and report any death which should be referred to the coroner by the registrar of births and deaths.”

<https://www.judiciary.gov.uk/publications/chief-coroners-annual-report-2016-17/>

This is congruent with a past, known high response rates to Rule 43 reports, the predecessor to Section 28 reports.^{3b}

An analysis of the Chief Coroner's published data up to the end of July 2017 revealed that of the Section 28 reports issued by this group of 21 coroners, only 36.8% (126 of 342) were accompanied by the relevant responses.

Therefore, it remains to be clarified how such a large proportion of responses are missing from the published record if these coroners are indeed sending all or most of the required material to the Chief Coroner's office.

The scale of missing responses is such that it is self-evidently not a matter of isolated administrative errors.

I will not publish these details of the 21 individual coroners whose accounts are at variance with the Chief Coroner's office, but I will share them with the Chair of the Public Administration and Constitutional Affairs Committee.

^{3b} MoJ Summaries of Reports and Responses under Rule 43 of the Coroners Rules July 2008 to March 2013

<https://minhalexander.files.wordpress.com/2016/09/july-2008-to-march-2009-summaryrule-43-v1.pdf>

<https://minhalexander.files.wordpress.com/2016/09/april-2009-to-september-summaryrule-43-v2.pdf>

<https://minhalexander.files.wordpress.com/2016/09/oct-2009-to-march-2010-thirdsummary-coroners-reports-rule43a.pdf>

<https://minhalexander.files.wordpress.com/2016/09/april-2010-to-oct-2010-rule-43-coroners-report-4th.pdf>

<https://minhalexander.files.wordpress.com/2016/09/oct-2010-to-march-2011-summaryrule-43-070312-5th.pdf>

<https://minhalexander.files.wordpress.com/2016/09/april-2011-to-september-2010-summary-rule-43-6th.pdf>

<https://minhalexander.files.wordpress.com/2016/09/oct-2011-to-march-2012-summaryrule-43-v7.pdf>

<https://minhalexander.files.wordpress.com/2016/09/april-2012-to-sept-2012-summaryrule-43-report-v8.pdf>

<https://minhalexander.files.wordpress.com/2016/09/oct-2012-march-2013-9th-rule-43-report.pdf>

Overall, issues of adherence to procedure notwithstanding, it appears that Section 28 reports are something of a legal dead end in the sense that there is no real power to compel parties to respond because there are no attached sanctions, and no clear means of dealing with unsatisfactory responses.

This is the correspondence to date with the Chief Coroner's office:

<https://minhalexander.files.wordpress.com/2017/08/correspondence-with-the-chief-coroner-about-section-28-reports.pdf>

The Department of Health and Social Care (DHSC)

By my previous calculations, the DHSC had been sent at least 176 Section 28 reports as a named respondent in the four years between July 2013 and July 2017. (The Department was additionally copied into other Section 28 reports).

Of these 176 reports, 134 reports had been directly addressed to the Secretary of State.

<https://minhalexander.files.wordpress.com/2018/01/section-28-reports-addressed-to-dh-up-to-july-2017.xlsx>

There were no published responses by the DHSC on the Chief Coroner's website to 106 out of the 176 (60.2%) Section 28 reports at the end of July 2017.

As of 12 January 2018, there were still no published responses for 73 of these 176 (41%) responses.

The DHSC advised me that it does not analyse Section 28 data:

"I can confirm that the Department does not conduct central analysis of prevention of future deaths reports where matters of concern are raised relating to the health and care sectors."

Whilst the DHSC acknowledged that Section 28 data is "valuable", it suggested that there was little value in analysing the data because it is insufficiently standardised:

"I would point out that there are a number of variable factors to bear in mind when attempting to draw conclusions from the material published online. For example, it is a matter for individual coroners to determine if, and when, a report on action to prevent future deaths should be made, and to whom. It may be the case that some coroners utilise this tool more than others, meaning that discerning any notable themes or patterns, such as commonly featured NHS trusts, can lead to misleading conclusions."

However, such an argument does not stop the government from analysing NHS critical incident data, which is also affected by variable reporting. It would seem

therefore that the DHSC's position and given reason for not analysing Section 28 data is inconsistent with its position on other matters.

Moreover, if the government genuinely held the belief that the data is unfit for analysis, it should have taken action years to redress this. But as no more than mere encouragement has been applied to the handling of Section 28 reports³, a question arises about the political will to protect quality.

In any case, analysis of data such as Section 28 reports can be valuable when interpreted with caveats, and may serve as a prompt to more in depth investigations.

The DHSC advised that its officials were not aware that the Department had ever asked for the Chief Coroner not to publish any of its responses to Section 28 reports:

"I can confirm that officials are not aware of any such instances."

However, this was based on broad recollections, and not full interrogation of the Department's files, which the DHSC advised would have been too time consuming.

The DHSC failed to respond specifically to the following questions:

- 1) *What data does the DHSC hold centrally on Section 28 reports? What fields feature in the DHSC's database?*
- 2) *If the DHSC holds the information centrally, how many Section 28 reports has it received since Section 28 reports were introduced in 2013, to what issues and NHS bodies have these Section 28 reports related, and what action has the DHSC taken in response to these Section 28 reports?*

If the above data is held, please provide it in the form of a spreadsheet, and if the data is centrally held and it is practicable to do so please include the names of the deceased, the coroner's case reference numbers and dates of the Section 28 reports.

- 3) *Does the DHSC hold central data on the number of Section 28 reports that have led to a system wide alert being issued? If so, please provide details of any such alerts, and please in particular include alerts issued via the DHSC's Central Alerting System.*

The DHSC's references to the unfeasibility of manual data searches implies that it does not collate data on Section 28 reports that it has received or how the reports have been handled.

The DHSC refused to disclose copies of some its responses to Section 28 reports that were missing from the Chief Coroner's published record, or to disclose details of the Section 28 reports to which it had responded:

“As the process for the publication of this material is outside the Department’s remit, the Department will not provide copies of the responses to the reports you specifically highlighted, nor the details of all the reports to which the Department has responded, which in any case would involve considerable resource.”

These are some key Section 28 reports to which the DHSC neither confirmed nor denied it had responded, and for which it declined to provide copies of any responses issued:

Death of Kevin Dermott in custody with contributory neglect

<https://www.judiciary.gov.uk/publications/kevin-dermott/>

Death of Nathaniel Phillips who could not afford asthma medication

<https://www.judiciary.gov.uk/publications/nathaniel-phillips/>

Death of Robert Hogg due to sepsis related to NHS 111 services

<https://www.judiciary.gov.uk/publications/robert-hogg/>

Death of Elizabeth Lester relating to flawed ambulance algorithms

<https://www.judiciary.gov.uk/publications/elizabeth-lester/>

Death of Paul Murray with contributory ambulance delay

<https://www.judiciary.gov.uk/publications/paul-murray/>

Death of Peter Scott after ambulance delay

<https://www.judiciary.gov.uk/publications/peter-scott/>

Death of Constance Pridmore under UHMBT relating to national shortage of radiologists

<https://www.judiciary.gov.uk/publications/constance-pridmore/>

Death of George Taylor under Cornwall Partnership NHSFT

<https://www.judiciary.gov.uk/publications/george-taylor/>

Death of Mary Fenton and concerns about the national pharmaceutical supply chain

<https://www.judiciary.gov.uk/publications/mary-fenton/>

At the time of writing this, there are still no responses by the Department of Health published on the Chief Coroner’s website except in these two cases:

Robert Hogg

<https://www.judiciary.gov.uk/publications/robert-hogg/>

Elizabeth Lester

<https://www.judiciary.gov.uk/wp-content/uploads/2015/05/2015-0204-Response-by-Department-of-Health.pdf>

The DHSC gave no specific responses to the following requests:

- 7) *In the interests of setting an example on accountability and transparency, can the DHSC publish all its responses to coroners' Section 28 reports on action to prevent future deaths that have been received to date, and all future responses to Section 28 reports?*
- 8) *Can the DHSC make it NHS policy for all Section 28 report responses by all NHS bodies to be published in future?*
- 9) *Can the DHSC make it NHS policy for all NHS bodies to provide information in their annual reports on Section 28 reports received and their responses to Section 28 reports?*

It is likely that in regards to question (7) and (8) the DHSC would rely on its general comment that publication of Section 28 reports is not within its remit.

However, there is nothing to stop the DHSC from implementing point (9).

This is the correspondence with the DHSC:

<https://minhalexander.files.wordpress.com/2017/08/letters-to-jeremy-hunt-section-28-reports-29-august-2017-and-8-september-2017.pdf>

<https://minhalexander.files.wordpress.com/2017/08/letter-to-jeremy-hunt-section-28-reports-5-dec-2017.pdf>

<https://minhalexander.files.wordpress.com/2017/08/dh-letter-to-jeremy-hunt-coroners-section-28-reports-5-12-2017-appendix-list-of-withheld-responses-to-s28-reports.pdf>

<https://minhalexander.files.wordpress.com/2017/08/dh-response-section-28-reports-de-1096208-10-oct-2017.pdf>

<https://minhalexander.files.wordpress.com/2017/08/dh-response-section-28-reports-10-october-2017.pdf>

NHS England

I found from the Chief Coroner's published data that NHS England had been sent at least 88 Section 28 reports as a named respondent.

<https://minhalexander.files.wordpress.com/2017/08/section-28-reports-addressed-to-nhs-engand-up-to-july-2017.xlsx>

At the end of July 2017, there were no published responses from NHS England to 67 of these 88 (76%) Section 28 reports. As of 12 January 2018, there were still no responses to 62 of these 88 (70.4%) reports.

NHS England was copied into many other Section 28 reports.

NHS England took three months to respond to my enquiry about its handling of Section 28 reports and only replied after I wrote to Simon Stevens CEO himself to protest at the delays.

NHS England advised that its records, dating from 2015, showed that 52 Section 28 reports had been received up to 30 August 2017.

NHS England's reply implied by omission that it started central analysis of Section 28 data only last year.

A detailed internal report was produced in June 2017, covering the period April 2016 to April 2017.

Contrasting with the DHSC's lukewarm tone, NHS England's report took the view that coroners' Section 28 data is:

"...a reliable source of evidence that would assist us in prioritising issues, taking action and providing us with valuable opportunities for learning from deaths in care."

The NHS England analysis noted that the two trusts (both in Sussex) which had been flagged most frequently by coroners' reports for neglect and omissions in care had anomalously been rated as 'Good' by CQC on the 'Caring domain':

CQC ratings for the two providers with highest number of findings of neglect or omissions in care

Organisation Date of report	Overall finding	Domain safe	Effective	Caring	Responsive	Well-led
Brighton and Sussex University Hospital NHST 17.8.16	inadequate	requires improvement	requires improvement	good	good	requires improvement
Sussex Partnership NHS Foundation Trust 23.12.16	requires improvement	requires improvement	requires improvement	good	good	requires improvement

Both organisations were rated as good for caring – these inspections were undertaken in 2016.

NHS England’s analysis concluded that improvements could be made to its process of learning of Section 28 reports, and how learning was cascaded through the organisation.

NHS England did not appear to have considered sharing the learning with service providers or with the public.

NHS England indicated that it had recently established a working group:

*“A new working group has been recently established to discuss issues raised by regulation 28 reports on a rolling basis, to examine what learning can be developed from coroners regulation 28 letters, and to provide advice (clinical or other) and regional insight into addressing the concerns raised by the coroner. Please find **enclosed**:*

- *an update paper from the working group,*
- *the relevant extract from a Key Data Report of the Quality Assurance Group,*
- *a Review of Coroner Regulation 28 Reports (1 April 2016 – 30 April 2017) for the South Region (Document 5).”*

However, NHS England appears to have no action plan on pooling learning with other bodies, despite its above observations that CQC ratings had seemed at odds with coroners’ findings.

NHS England declined to disclose its responses to the following Section 28 reports:

Death of Dean Saunders in custody
<https://www.judiciary.gov.uk/publications/dean-saunders/>

Death of Emmanuel Akinmuyiwa from sickle cell anaemia with contributory neglect

<https://www.judiciary.gov.uk/publications/emmanuel-akinmuyiwa/>

Death of Shalane Blackwood in custody

<https://www.judiciary.gov.uk/publications/shalane-blackwood/>

Death of Craig Bell in custody

<https://www.judiciary.gov.uk/publications/craig-bell/>

Death of Colin Sluman after ambulance delay

<https://www.judiciary.gov.uk/publications/colin-james/>

Death of Benjamin Orrill by suicide after being seen by an 'advance practitioner' nurse

<https://www.judiciary.gov.uk/publications/benjamin-orrill/>

Death of Michael Parke from misplaced nasogastric tube and 'systemic neglect'

<https://www.judiciary.gov.uk/publications/michael-parke/>

Death of John Stabler in custody

<https://www.judiciary.gov.uk/publications/john-stabler/>

Death of Adam Withers a detained patient

<https://www.judiciary.gov.uk/publications/adam-withers/>

At the time of writing, NHS England's responses have still not been published except in these two cases:

Dean Saunders

<https://www.judiciary.gov.uk/wp-content/uploads/2017/03/2017-0056-Response-by-NHS-England.pdf>

Colin Sluman

<https://www.judiciary.gov.uk/wp-content/uploads/2017/07/2017-0200-Response-by-NHS-England.pdf>

Notwithstanding, NHS England advised that it has never asked for its responses to Section 28 reports to be withheld from publication.

Neither NHS England's thematic analysis nor other disclosed documents give a clear picture of *action plans* for themes that emerged from Section 28 reports, nor for individual Section 28 reports.

The legal advice given to NHS England in respect of individual Section 28 reports was redacted from database information that NHS England has disclosed.

NHS England has also indicated that it has withheld some material on grounds of confidentiality to deceased patients.

NHS England did not give specific responses to this question on whether it would use its commissioning power to ensure that provider bodies are more transparent in future about Section 28 report activity:

9. *“Can NHS England make it a core, standard commissioning requirement that all NHS providers should in future publish all the Section 28 reports that they receive, and their responses to these Section 28 reports, and give an account of their Section 28 activity in their annual reports?”*

This is the correspondence with NHS England, its thematic analysis of coroner’s Section 28 reports and other disclosed documents:

<https://minhalexander.files.wordpress.com/2017/08/letter-to-simon-stevens-re-section-28-reports-30-august-2017.pdf>

<https://minhalexander.files.wordpress.com/2017/08/nhs-england-section-28-foi-29-11-2017-response-our-reference-foi054303.pdf>

<https://minhalexander.files.wordpress.com/2017/08/nhs-england-foi-section-28-reports-file1regulation28-spreadsheetcase-tracker-redacted.pdf>

<https://minhalexander.files.wordpress.com/2017/08/nhs-england-foi-section-28-reports-file2copyofcorrespondencelog1516pdf.pdf>

<https://minhalexander.files.wordpress.com/2017/08/nhs-england-foi-section-28-reports-document3updatepaperfromworkinggroup-v1-redacted.pdf>

<https://minhalexander.files.wordpress.com/2017/08/nhs-england-foi-section-28-reports-document4keydatareportextractpdf.pdf>

<https://minhalexander.files.wordpress.com/2017/08/nhs-england-foi-section-28-reports-document5reviewofreg28reportspdf-v11.pdf>

Care Quality Commission

I found from the Chief Coroner’s published data that 47 coroners’ Section 28 warning reports had been sent to CQC as a named respondent in the four year period up to July 2017, but that there were no published CQC responses to 33 of these notices.

<https://minhalexander.files.wordpress.com/2017/08/all-section-28-reports-on-action-to-prevent-future-deaths-published-by-chief-coroner-up-to-31-july-2017-pub.xlsx>

[See sheet 2]

There has been past scandal over the CQC's failure to act upon coroners' warning reports.^{4 5 6 7}

The CQC has at times obfuscated over exactly what governance it has in place with regards to coroners' reports.⁸

In response to my most recent enquiries, the CQC clarified that its dedicated email inbox for Section 28 reports was created in September 2014, and started receiving routine notifications of *all* coroners' warning since at least December 2014:

"We can advise you that the earliest report we have recorded centrally is dated 18 December 2014"

⁴ Elderly people put at risk as watchdog fails to act on warnings of 'fatally negligent' care homes, Melanie Newman and Oliver Wright, Independent, 2 September 2015
<http://www.independent.co.uk/life-style/health-and-families/health-news/elderly-people-put-at-risk-as-watchdog-fails-to-act-on-warnings-of-fatally-negligent-care-homes-10483573.html>

Death of Isle of Wight care home resident at centre of national investigation, Sally Perry, On the Wight, 9 September 2015
<https://onthewight.com/death-of-isle-of-wight-care-home-resident-at-centre-of-national-investigation/>

⁵ Autumn's Fall, Private Eye Issue 1412, February 2016 about poor care at Autumn Grange care home in Nottingham and the death of Ivy Atkin

⁶ Care home deaths and more broken CQC promises, 8 October 2016
<https://minhalexander.com/2016/10/08/care-home-deaths-and-more-broken-cqc-promised/>

⁷ Who speaks for the dead? Ivy Atkin and the unaccountable CQC. 22 October 2017
<https://minhalexander.com/2017/10/22/who-speaks-for-the-dead-ivy-atkin-and-the-unaccountable-cqc/>

⁸ There has been discrepancy between information that CQC has disclosed to me and CQC's annual reports, statements and a press release in response to the joint Bureau of Investigative Journalism and Independent coverage of CQC's failures to act on coroners' warnings, about when and how CQC started monitoring coroners' Section 28 reports.

CQC advised that its records show that it received a total of 1,109 Section 28 reports since then (albeit not all through the dedicated email address).

CQC responded gingerly on whether it had conducted any central analyses of Section 28 reports received. It replied that only an analysis of “gathered” Section 28 reports had been undertaken by one of its teams for the financial year 2014/15.

Initially, CQC claimed that much of this analysis was exempt from disclosure:

“This analysis is conducted on a case by case basis to inform inspectors and the source material includes confidential information about people who use services, much of the information would be exempt from disclosure as personal and confidential information.”

But after a further request was made for a copy of the analysis, CQC disclosed it in full, with no explanation of why it had originally claimed that much of the content would be exempt from disclosure.

The disclosed documents showed that CQC had analysed Section 28 reports with respect to different sectors: primary medical services, ambulance services, acute services, adult social care services and mental health services, and was aware of broad themes arising from the data.

For example, CQC’s analysis of Section 28 reports relating to ambulance services shows that CQC was aware of the strains on ambulance service and of national issues:

“One coroner linked understaffing in the ambulance sector to a general squeeze on resources throughout the acute sector, and ‘bed blocking’, addressing their concerns to the Secretary of State rather than the trust itself.”

“There were also a number of concerns raised around the effectiveness of call centre staff members’ interactions with other services and organisations, be that BT (to obtain an address from a telephone number) or other emergency services, including neighbouring ambulance services, which is potentially a national-level problem.”

“In two deaths where concerns were raised about the call handling aspect, failure on the part of call centre staff to recognise the seriousness of the person’s illness, and thus despatch an ambulance, was highlighted by the coroner. This again points to staff training needs in call centres dealing with emergencies or potential emergencies, as well as improved protocols for triaging calls. In one case, these concerns were addressed to a body that is not CQC-regulated (NHS England) and not to the ambulance trust, but are nonetheless of relevance to this report in that a potentially nationwide concern has been identified.”

CQC's ratings of four ambulance trusts as 'Good' or 'Outstanding' seem incongruous given on what CQC knew about national pressures on the ambulance service, based on its thematic analysis.

Ambulance trust	Current CQC rating
East Midlands Ambulance Service	Requires Improvement
East of England Ambulance Service	Requires Improvement
London Ambulance Service	Requires Improvement
North East Ambulance Service	Good
North West Ambulance Service	Requires Improvement
South Central Ambulance Service	Good
South East Coast Ambulance Service	Inadequate
South Western Ambulance Service	Requires Improvement
West Midlands Ambulance Service	Outstanding
Yorkshire Ambulance Service	Good

Source: CQC inspection reports

CQC's analysis on acute services revealed a trend for a greater number of Section 28 reports relating to the North region:

DEMOGRAPHIC INFORMATION

A total of 146 PFD Reports where there was acute services involvement, written by coroners between March 2014 and April 2015, have been analysed. (See Tables 1 and 2 below).

Table 1: PFD Reports sample distribution by region.

	2014	2015	Total
London	17	5	22
Central	21	10	31
East	10	2	12
North	33	21	54
South	21	6	27
Total	102	44	146

CQC's thematic analysis of Section 28 reports on Adult Social Care Services for the period 2014/15 noted that CQC had been asked to consider national standards for night time staffing in care homes and hospitals:

From the report touching the death of J Gwynfryn Morris (PFD0697), a recommendation aimed at CQC:

'I know that many hospitals are looking carefully at their staffing levels at night particularly in the wards where patients suffer from dementia and may be at a risk of falls through wandering and I am drawing this case to your attention so that you and your inspectors can look carefully at whether staffing levels for night time are adequate to meet the various needs of all the residents/patients in residential, nursing and hospital environments.'

The inclusion of CQC as an organisation needing to take action was uncommon in the sample of reports analysed, and the above was the only explicit recommendation made in relation to CQC.

However, CQC's thematic analysis made no comment on action taken in response to this very significant Section 28 report.

CQC's response to this Section 28 report was never published by the Chief Coroner. CQC also refused to disclose it to me.

The issue of night time staffing was integral to a controversial whistleblower case in which CQC's actions have been seriously criticised.

<https://minhalexander.com/2017/12/16/cqcs-asleep-on-the-night-shift/>

But I recently noted that CQC's 2014 response to the Section 28 report had been quietly published on the Chief Coroner's website:

<https://www.judiciary.gov.uk/wp-content/uploads/2013/12/2013-0295R.pdf>

CQC side-stepped the coroner's central concern that standards should be set for night time staffing. The regulator promised to consider "sufficiency of staffing levels" in a national report on dementia in the summer of 2014. CQC later published a report in October 2014⁹. This made only a cursory reference to the need for enough staff in

⁹ Cracks in the pathway. People's experiences of dementia care as they move between care homes and hospitals. CQC October 2014.

https://www.cqc.org.uk/sites/default/files/20141009_cracks_in_the_pathway_final_0.pdf

care homes. It gave no specific guidance whatsoever. It did not even mention the suitable number of staff for night time:

“4.4.3 Numbers of staff The time staff had to spend with people, over and above providing the required aspects of personal and clinical care, varied across the care homes and hospitals visited. However, it was often a significant factor in caring for people living with dementia. We spoke to several managers and staff who expressed frustration that, due to a lack of resources, they were not able to provide the care needed.

We saw how people living with dementia were affected when there was not enough staff, including changes to their behaviour that caused distress to them and others around them.”

So CQC essentially gave the coroner bland assurances but did not actually address the identified risks in order to prevent future deaths. This was not an isolated example.

With regards to mental health services, CQC has powers to investigate concerns about care given under the Mental Health Act (MHA):

“If the complaint is about care and treatment under the Act, the complaint can be made to the service provider, commissioner, or CQC.”¹⁰

Complaints can be made by or on behalf of detained patients, and ultimately escalated all the way up to the Secretary of State.

It would seem reasonable that when coroners issue Section 28 reports about the care of patients who die whilst detained under the MHA, CQC should investigate these untoward deaths, particularly given the State’s special duty of care to those whom it detains.

But when I asked CQC if it held information about adverse coroners’ findings about the deaths of patients detained under the Act, CQC swerved the question with a play on words:

“3) Does CQC hold central data on how many Section 28 report notifications (whether addressed to CQC as a named correspondent or sent to CQC for information) on the deaths of patients detained under the Mental Health Act triggered an investigation, with respect to CQC’s inherited powers from the Mental Health Act Commission?”

[CQC answer] CQC does not have any powers to investigate deaths of detained patients that differ from the duties and responsibilities inherited from the HSE. Deaths of all patients (detained or otherwise) are considered by our

¹⁰ Mental Health Act 1983 Code of Practice
http://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/01/Code_of_Practice.pdf

inspection colleagues and actioned as necessary. All Regulation 28 reports would be considered in line with other information – there is no differential practice for detained patients.”

For good measure, CQC also maintained that it would take too long to search manually for the information.

And yet CQC’s thematic analysis of Section 28 reports about mental health services acknowledged many systemic failings, which would be pertinent to Article 2 issues in the deaths of detained patients.

Based on CQC’s disclosures so far, it is unclear what learning from CQC’s 2014/15 analysis of Section 28 reports was shared across the organisation and what action CQC took as a result of the learning.

Indeed, CQC advised in related correspondence that it had not kept a consistent, central record of action taken in response to Section 28 reports until April 2017:

“Our database does not contain categorised data summarising the nature of concerns raised by coroners in Regulation 28 Reports. Our database does contain categorised data on the actions taken in response to Regulation 28 Reports but this data has only been consistently and comprehensively recorded since April of this year”

A question also arises about why CQC did not share the learning from the 2014/15 thematic analysis with providers and with the public:

“These reports were written for an internal audience as part of exploratory work to understand the content of the reports and inform further analytical approaches.”

CQC initially admitted that it had asked for the Chief Coroner not to publish some of its responses to Section 28 reports, and advised that this was because publication would interfere with enforcement activity:

“We believe there have been instances where CQC has asked the Chief Coroner not to publish our full response where doing so would have prejudiced ongoing enforcement activity.”

However, the responses appeared to have been withheld on a permanent basis, long after any enforcement action has concluded, judging from responses that were missing from the Chief Coroner’s website.

Moreover, CQC declined to say how many times it had asked for its responses not to be published:

“We consider section 12 to be engaged in relation to this question as extensive manual searches would be required to identify such instances.”

However, after the Chief Coroner's office maintained that it had *not* received any requests from CQC not to publish responses to Section 28 reports, CQC indicated that it accepted this alternative account of events.

CQC declined to disclose its responses to the following Section 28 reports:

Death of Ozan Atasoy a detained patient after absconding
<https://www.judiciary.gov.uk/publications/ozan-atasoy/>

Death of Terence Brooks due to Legionella infection with poor system response
<https://www.judiciary.gov.uk/publications/terence-brooks/>

Death of Neil Carter with 'deliberate falsification' of the patient record by Priory Group staff
<https://www.judiciary.gov.uk/publications/neil-carter/>

Death of Mohammed Chaudhury with pressure sores of unusual extent and severity which developed whilst he was in hospital
<https://www.judiciary.gov.uk/publications/mohammed-chaudhury/>

Death of Barbara Cooke from pressure sores with contributory neglect
<https://www.judiciary.gov.uk/publications/barbara-cooke/6>

Death of Robert Entenman at a private hospital after his humidifier was switched off
<https://www.judiciary.gov.uk/publications/robert-entenman/>

Death of Edwin Thompson with contributory neglect
<https://www.judiciary.gov.uk/publications/edwin-thompson/>

Death of Derrick Rivers with institutional abuse and criticism of CQC's failure to review medicines management which was a contributory factor in the death, Section 28 report sent to you personally.
<https://www.judiciary.gov.uk/publications/derrick-rivers/>

Death of Dennis Teesdale after perforation of bowel from PEG insertion, with breach of clinical protocol, Section 28 report sent to you personally.
<https://www.judiciary.gov.uk/publications/dennis-teesdale/>

At the time of writing, CQC's responses to the above Section 28 reports are still missing from the Chief Coroner's website save in these four cases:

Ozan Atasoy
https://www.judiciary.gov.uk/wp-content/uploads/2014/04/2014-0166-Response-by-Care-Quality-Commission_Redacted.pdf

Neil Carter

<https://www.judiciary.gov.uk/wp-content/uploads/2014/03/2014-0103-Response-by-Care-Quality-Commission.pdf>

Robert Entenman

<https://www.judiciary.gov.uk/wp-content/uploads/2017/02/2017-0011-Response-by-Care-Quality-Commission.pdf>

Dennis Teesdale

<https://www.judiciary.gov.uk/wp-content/uploads/2017/07/2017-0202-Response-by-Care-Quality-Commission.pdf>

Important details emerge from these hitherto suppressed CQC documents. For example, CQC's just published response of March 2017 to the coroner about Robert Entenman reveals that the private hospital provider initially claimed to the CQC that his death, which was due to a human error in switching off a humidifier, was 'expected'. CQC currently rates this private provider as 'Outstanding'.

Missing from all of the material disclosed by CQC so far is what CQC learnt from the Section 28 reports that criticised its own actions or omissions.

Indeed, in the terrible death of Ivy Atkin at Autumn Grange care home, CQC fiercely resisted disclosure of its internal review into the death.⁷ This document still remains hidden from the public, and the local authority has similarly released only a summarised account of its review of events.

CQC did not respond to the following requests:

- 8) *In the interests of setting an example on accountability and transparency, can CQC publish all its responses to coroners' Section 28 reports on action to prevent future deaths that have been received to date, and all future responses to Section 28 reports?*
- 9) *Can CQC in future provide a meaningfully detailed account in its annual reports on the number of Section 28 reports that it has received and provide suitably informative, in depth trends analysis of the data, including provider level data?*

Where CQC is sent Section 28 reports as a named respondent for action to prevent future deaths, can CQC itself in future transparently account for its own actions in response to coroners, in its annual reports?

- 10) *Can CQC make it a core, standard inspection standard to always review and report on Section 28 reports received by provider organisations, and the action that provider organisations have taken in response to Section 28 reports?*

Can CQC consult on the production of appropriate regulatory standards for governing this aspect of inspection?

I ask as I have found from reviewing a large number of CQC inspection reports that CQC's reporting approach is erratic and that CQC sometimes inexplicably makes no reference at all to important coroners' findings on patient safety in its inspection reports."

When I reminded CQC about these requests, I received this now familiar rebuff from David Behan via his office:

"Dear Dr Alexander

On behalf of Sir David, thank you for your email of 5 October. CQC will keep the suggestions you make under consideration. We do not intend to engage in further correspondence with you on this matter.

Yours sincerely,

*Matt Docherty
Correspondence Secretary"*

This is the correspondence with CQC and all documents disclosed by CQC so far:

<https://minhalexander.files.wordpress.com/2017/08/letter-to-david-behan-section-28-reports-1-09-2017.pdf>

<https://minhalexander.files.wordpress.com/2017/08/cqc-29-09-2017-foi-section-28-reports-20170929-1558-foi-final-response-cqc-iat-1718-0390.pdf>

<https://minhalexander.files.wordpress.com/2017/08/cqc-foi-response-29-09-2017-data-on-section-28-reports-received-by-cqc-20170929-foi-final-decision-notice-cqc-iat-1718-0390.pdf>

<https://minhalexander.files.wordpress.com/2017/08/cqc-foi-standard-operating-procedure-for-handling-section-28-reports-1-20170728-inp004-standard-operating-procedure-coroner-v0-04 redacted.pdf>

https://minhalexander.files.wordpress.com/2017/08/cqc-foi-step-by-step-internal-guidance-on-handling-section-28-reports-2-20170216-step-by-step-guidance-coroner-correspondence_redacted.pdf

<https://minhalexander.files.wordpress.com/2017/08/cqc-foi-staff-guidance-what-is-a-section-28-report3-20150000-handling-a-regulation-28-report intranet.pdf>

<https://minhalexander.files.wordpress.com/2017/08/cqc-foi-20160517-coroners-reports-pms-sector-thematic-analysis-final-redacted.pdf>

<https://minhalexander.files.wordpress.com/2017/08/cqc-foi-20160512-coroner-reports-amb-analysis-final.pdf>

<https://minhalexander.files.wordpress.com/2017/08/cqc-foi-20160517-coroners-reports-acute-sector-thematic-analysis-final-redacted.pdf>

<https://minhalexander.files.wordpress.com/2017/08/cqc-foi-20160517-coroners-reports-asc-sector-thematic-analysis-final.pdf>

<https://minhalexander.files.wordpress.com/2017/08/cqc-foi-20160517-coroners-reports-mh-sector-thematic-analysis-final.pdf>

<https://minhalexander.files.wordpress.com/2017/08/cqc-12-december-2017-re-withholding-responses-to-coroners-section-28-reports-from-publication.pdf>

NHS Improvement

I found only one Section 28 report that NHS Improvement (and or its predecessors) had been sent as a named respondent, but it was a very important report about the national approach to managing ligature point risk.

Death of Helen Millard under the care of Humber NHS Foundation Trust

Expert evidence was adduced from a number of expert witnesses and Consultant Psychiatrists that at least 50% of deaths due to hanging in inpatient psychiatric facilities occur from ligature points which are one metre or less in height above the ground. Patients merely need to learn forward and tighten the ligature around their neck under their body weight and they collapse into unconsciousness within ten to twenty seconds and death can occur in as little as two to three minutes. This evidence was backed up by peer reviewed literature which was also read out during the course of the Inquest.

My principal concern is that there is an obvious incongruity in the classification system as effectively all ligature points, no matter what their height, should be regarded as representing extreme risks. Evidence was heard that the risk is independent of height and consideration needs to be given to classifying all ligature points once identified as 'red' and their elimination tackled on an urgent basis.

<https://www.judiciary.gov.uk/publications/helen-millard/>

Humber NHS Foundation Trust is of course also well known for the highly controversial death of Sally Mays. Illustrating the variability of the coronial system,

Sally May's family have advised me that Humber escaped a PFD. This was despite serious care failings and a finding of a neglect.¹¹

In response to enquiries about its approach to Section 28 reports, NHS Improvement advised:

"Neither Monitor nor the NHS Trust Development Authority had formal governance arrangements for handling intelligence from section 28 reports prior to integration."

But:

"NHS Improvement has recently developed internal guidance for the management of Section 28 Reports"

NHS Improvement pointed out that Monitor's guidance required foundation trusts to inform it of reports which called compliance with their terms of authorisation into question:

"Monitor's Risk Assessment Framework noted "Many third parties, including other regulators, auditors, medical Royal Colleges, training establishments and coroners, comment on and review aspects of an NHS foundation trust's performance. We do not require NHS foundation trusts to send us each and every report that includes commentary or observation on their performance. However, we do require trusts to inform us of reports that can reasonably be regarded as raising potential concerns over a trust's current or potential compliance with licence conditions, in particular the NHS foundation trust governance condition."

It would seem sensible for NHS Improvement to have a more assured means of alert, for example, by pooling efforts with CQC and benefiting from coroners' routine notifications to CQC about Section 28 reports.

NHS Improvement declined to disclose a copy of its response to the above important Section 28 report on Helen Millard's death, which raised concerns about the NHS' approach to ligature points, especially low level ligature points.

At the time of writing, NHS Improvement's response remains unpublished.

I have worked in services where managers have failed to take identified ligature points seriously for years. In one service, thousands of actionable ligature points were left from one critical CQC inspection to the next, unbelievable as that sounds.

¹¹ Take action against this failing health service watchdog, Yorkshire Daily Post 16 January 2017
<https://www.yorkshirepost.co.uk/news/take-action-against-this-failing-health-sevice-watchdog-1-8335776>

The cost of a rigorous, properly coordinated, national ligature point elimination programme in the NHS would require substantial resource.

Instead, NHS Improvement has published a home study case study showing how one trust, Oxleas, made do and mended.

The key phrase from this NHS Improvement document is:

“However, as for many other trusts, it was not possible to remove every potential hazardous ligature point: there were some that could either not be practically removed, or such removal would be so costly that the trust could not afford it.”

<https://minhalexander.files.wordpress.com/2018/01/nhs-improvement-oxleas-ligature-points-case-study-june-2017.pdf>

And that I suspect, is probably the fundamental leitmotif of the government’s evasions and obfuscations on its responses to coroners’ warnings.

So is it value, or price, that we should set on human life?

This is the correspondence with NHS Improvement:

<https://minhalexander.files.wordpress.com/2018/01/letter-to-jim-mackey-section-28-reports-14-09-2018.pdf>

<https://minhalexander.files.wordpress.com/2018/01/nhs-improvement-foi-section-28-reports-alexander-decision-letter-12-10-2017.pdf>

<https://minhalexander.files.wordpress.com/2018/01/nhs-improvement-foi-section-28-report-process-redacted.pdf>

END

