Department of Health & Social Care

From Neil O'Brien MP
Parliamentary Under Secretary of State for Primary Care and Public Health
39 Victoria Street
London
SW1H 0EU

Graeme Irvine
Acting Senior Coroner
Coroner Area of East London
Walthamstow Coroner's Court
Queens Road Walthamstow
E17 8QP

15 February 2023

Dear Mr Irvine,

Thank you for your letter of 18 July 2022 about the death of Mr Graham Edgar White. I am replying as Minister with responsibility for Health and Secondary Care and I thank you for the additional time allowed.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr White's death and I offer my sincere condolences to their family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention.

In preparing this response, Departmental officials have made enquiries with NHS England and the Care Quality Commission.

The Care Quality Commission (CQC) inspected the Barking, Havering and Redbridge University Trust in November 2021 where the Urgent Care and Emergency Services (UEC) at the Queen's Hospital were inspected. Concerns were identified and the Trust worked with local system partners to create an action plan to address these. CQC intends to inspect the UEC at the Queen's Hospital again and will consider the Trust's response to the Coroner in these inspection plans. In the meantime, CQC will monitor the Trust's review of this patient group through regular engagement.

After Mr White's death, CQC carried out an initial management review and agreed to seek assurance that the Trust was taking action to mitigate risk, establish oversight of patients with stents, and address the governance concerns regarding the escalation of the incident. The Trust informed CQC that they had initially commenced a review of all 1,200 patients that had been fitted with a stent over the previous three years and had agreed to extend the review for all patients who have since had their stent removed. Early findings were that the COVID-19 Pandemic had impacted their oversight of this patient group.

Barking, Havering and Redbridge University Trust has completed a comprehensive Serious Incident/Root Cause Analysis following Mr White's death. They have made several recommendations including: providing patients with information leaflets and stent cards that confirm when a stent should be taken out and a contact number providing a direct line to the admissions office if no appointment has been confirmed within 12 weeks; an electronic stent register that has been operational since May 2022, providing alerts and prompts to the service for timely removal of stents; the need for a standard operating procedure across the Trust for optimal stent management; a requirement to investigate non-attendance at clinics before patients are discharged; an audit of all patients with stents inserted between 1 April 2019 and 31 March 2022; to undertake an assessment of demand and capacity for treating stone patients; and to strengthen the process of incident reporting and the detection of potential incidents.

NHS England will be working with providers, patient representatives and partners, such as specialist societies, to implement outcome registries across implant procedures, including urology and stent procedures. These registries will enable secure patient level data collection that includes the devices used and the patient outcomes. They will improve device vigilance in direct care, and the monitoring of patient safety and outcomes.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours Sincerely

NEIL O'BRIEN MP