Department of Health & Social Care

From Maria Caulfield
Parliamentary Under Secretary of State for
Mental Health and Women's Health Strategy

39 Victoria Street
London
SW1H 0EU

[redacted]

[redacted]

Mr Graeme Irvine
HM Senior Coroner
Walthamstow Coroner's Court
Queens Road
Walthamstow
E17 8QP

3 February 2023

Dear Mr Irvine,

Thank you for your letter of 12 September 2022 about the death of Mrs Delina Etienne. I am replying as Minister with responsibility for Mental Health and Patient Safety at the Department of Health and Social Care.

Firstly, I would like to say how deeply saddened I was to read of the circumstances of Mrs Etienne's death. I can appreciate how distressing her death must be for her family and those who knew and loved her and I offer my heartfelt condolences. It is vital that we take the learnings from what happened to prevent future deaths 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 (CQC).

I understand that several actions have been taken by the East London NHS Foundation Trust following the death of Mrs Etienne. I am pleased to see that an action plan was produced and covered all the areas of concerns that you raise in your report, including medical simulation training, Life Support training and training on the correct escalation of a patient with chest pain for members of staff on the ward. I have also seen that the electronic recording system for National Early Warning Score (NEWS2) now has automatic alerts for all physical health observations recorded which are outside expected limits. As well as this, audits have been introduced on the ward to ensure that all patients have a venous thromboembolism assessment on admission.

I was particularly saddened to read that the family were only informed of the error regarding a Do Not Attempt Resuscitation (DNACPR) decision via the Serious Incident Report, rather than immediately after the incident. However, I understand this issue has been addressed by the Trust and that there was no intention to conceal an error by the staff member concerned. Further to this, there is now a monthly audit of the ward in relation to resuscitation

status record-keeping and CPR status is now a formal part of the handover for each nursing shift.

I am further reassured that the CQC have received updates on the Trust's action plan and will continue to monitor its implementation through regular engagement meetings. Although an inspection has not been triggered as a result of this incident, the CQC will follow up with the Trust at its next inspection that the learning from this incident has been embedded.

I hope that this, along with the response from the Trust, has reassured you that action has been taken to address the concerns you have raised and to ensure a tragic death does not happen again.

Thank you for bringing these concerns to my attention.

Kind regards,

MARIA CAULFIELD MP