

From Maria Caulfield MP Parliamentary Under Secretary of State for Mental Health and Women's Health Strategy Department of Health & Social Care

> 39 Victoria Street London SW1H 0EU

Mr Graeme Irvine Senior Coroner East London East London Coroner's Court 124 Queens Road Walthamstow E17 8QP

13 May 2024

Dear Mr Irvine,

Thank you for your Regulation 28 report to prevent future deaths dated 31/10/2023 about the death of Ghulam Mohammad. I am replying as Minister with responsibility for patient safety.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Mohammad's death, and I offer my sincere condolences to their family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention. Please accept my sincere apologies for the delay in responding to this matter.

Your report raises concerns over an avoidable fall in hospital and following that fall, an urgently requested CT head was delayed for four days. Before the requested CT head was undertaken, a doctor prescribed blood thinning medication enoxaparin to Mr Mohammad. Enoxaparin can exacerbate an intra-cranial bleed. The inadequate record keeping meant that there was no contemporary account of the factors taken into consideration by the doctor or her supervising consultant in prescribing enoxaparin. Neither the Trust's initial serious incident investigation nor the consultant statement to the inquest mentioned the use of enoxaparin or the lack of clinical records justifying its use.

In preparing this response, Departmental officials have made enquiries with NHS England and the Care Quality Commission (CQC). By way of background, Barts Health NHS Trust is one of the largest NHS trusts in the country, having been formed by the merger of Barts and the London NHS trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust in April 2012. I note that the Chief Medical Officer at Barts Health NHS Trust wrote to you on 17 January 2023 setting out how it has addressed locally your five matters of concern in your prevention of future deaths report.

The Department is content that the CQC took regulatory action when in May 2021, the CQC received whistleblowing concerns from staff working in imaging departments at Barts Health NHS Trust. These concerns included a wide range of issues including staffing, patient risk, processes, and leadership. To address these concerns CQC, alongside the Health and Safety Executive (HSE), carried out focused inspections and CQC had issued warning notices at the imaging departments of the Royal London Hospital and Whipps Cross Hospital in May 2021. A further inspection to review progress regarding improvement plans were carried out in September 2021. CQC found that the provider has complied with the warning notices issued previously and had made improvements to ensure that diagnostic imaging services had more oversight of staffing rotas and risk assessments.

Given the historic concerns related to this core service Diagnostic Imaging at Barts Health NHS Trust remains on the risk register of the local team and is a priority for future inspection. Any inspection activity will also review the areas of concern identified in the last inspection report including processes for accessing high priority scans. The inspection report can be accessed on the CQC website at https://www.cqc.org.uk/location/R1H12/inspection-summary.

CQC continues to monitor the above issues, alongside concerns identified in this Regulation 28 Report, and have regular engagement with Barts Health and other key stakeholders on this matter.

I am writing to the Trust Chief Executive and the Chief Medical Officer seeking assurance that they do implement the changes to ensure patient safety is maintained both in preventing falls, but also ensuring staff have training to know when to act promptly should a head injury occur.

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

Best Wishes,

