Department of Health & Social Care

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

*39 Victoria Street*
*London*
*SW1H 0EU*

[redacted]

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

[redacted]

13 May 2024

Dear Mr Irvine,

Thank you for your letter of 9 February 2023 about the death of George Kearsey. 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 Kearsey'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. Please accept my sincere apologies for the significant delay in responding to this matter

The report raises concerns about the administration of IV fluids and the appropriate process of monitoring and documentation not being followed.

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

I am aware that Barking, Havering and Redbridge University Hospitals NHS Trust provided a response to your Regulation 28 report in April 2023, outlining the steps taken in response to the concerns identified.

Following further enquires with NHS England, the trust has provided the following update:

- Audits have been completed in Geriatrics and Frailty wards and the findings were presented at the monthly Clinical Group Quality & Safety meeting and the Quality Governance Steering Group. Across the 9 audited areas, over the period of three months (March, April and May 2023), the audits demonstrated that 87% of patients' fluid charts were completed, recorded on vital pac and available to review. Each patient that did not have fluid chart completed and recorded on vital pac (due to a new admission to the ward or if any had not been documented as expected) was reviewed. Audit results feedback was provided to the nursing staff by the relevant Ward Managers or Practice Development Nurses.

- The Quality and Safety Advisor completed a random spot check audit in June at Queen's Frailty Unit and Beech Frailty Unit to check that fluid charts were being completed and were available on vital pac. A total of 18 patients' records were audited and all had completed and detailed fluid charts in place and recorded on vital pac. Random spot check audits are continuing.
- The Clinical Safety Assessment on Vital pack was completed to ensure accurate data input and data availability.
- The Clinical Group have met George Kearsey's daughters as part of the complaint process and resolved their concerns. They have also been invited to attend Geriatrics and Frailty ward managers forum to share their story and provide face-to-face feedback to the nursing staff to highlight the importance of fluid monitoring.

The CQC continues to discuss and monitor the progress of actions taken during their regular engagement meetings with the Trust and how the Trust embeds learning remains a matter for their attention.

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

Best Wishes,

**MARIA CAULFIELD**