Department of Health & Social Care

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

[redacted]

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

[redacted]

13 May 2024

Dear Mr Irvine,

Thank you for the Regulation 28 (Preventing Future Deaths) report of 24th July 2023 in relation to the death of Christine Nakafeero. I am replying as Minister with responsibility for patient safety.

Please accept my sincere apologies for the delay in responding to this matter. I would like to assure you that the Department is mindful of the statutory responsibilities in relation to PFD reports and we are prioritising responses as a matter of urgency.

I would like to begin by saying how saddened I was to read about the circumstances of Ms Nakafeero's death and would like to offer my sincere condolences to her family and loved ones. It is vital that we learn from incidents where we can to improve NHS care.

I have noted the concerns raised in your report. The first relates to the Trust's failure to allocate an appointment for Ms Nakafeero to undergo a hysterectomy, coupled with the absence of a clear explanation as to why she slipped out of this care pathway. You also

expressed concern that Ms Nakafeero's venous-thrombo-embolism (VTE) risk was assessed by utilising an established algorithm based on national guidance but that despite this being done appropriately, it failed to identify two risk factors which made the formation of a deep vein thrombosis more likely.

I understand that the Care Quality Commission (CQC) engaged with Barts Health NHS Trust following Ms Nakafeero death, to understand what actions it was taking to address your concerns. The Trust explained that it was in the process of improving how it monitors outpatient outcomes and how it tracks patients along the pathway. To facilitate this, the Trust confirmed that it was implementing an improved digital monitoring tool for patient tracking lists to replace its electronic waiting list tool. I understand that CQC is monitoring the impact of this implementation and how the Trust assures itself that it is effectively monitoring all patients across care pathways.

The Trust also explained to CQC that it was seeking expert advice from Professor Roopen Arya, Professor of Thrombosis and Haemostasis at King's College Hospital and Director of the National VTE Exemplar Centres Network in England. Professor Arya advised the Trust that the use of the tool to assess VTE risk and determine intervention was appropriate and that at that time there was insufficient evidence to adapt or change this. I am aware that the Trust is also continuing to monitor the information it received from national bodies that informed how it implements best practice on prevention of VTE.

I would like to assure you that ensuring patients are safe is a priority for this Government. We have taken significant action over the last decade to advance patient safety and the response to harm in the NHS and, with our system partners, will continue to do all we can to stop harmful events from ever happening.

Thank you again for bringing your concerns to my attention.

Yours sincerely,

MARIA CAULFIELD