Department of Health & Social Care

*The Rt Hon. Andrew Stephenson CBE MP*
*Minister of State for Health and Secondary Care*

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

Mr Graeme Irvine,
Senior Coroner
East London Coroners Court
124 Queens Road
Walthamstow
E17 8QP

1st May 2024

Dear Mr Irvine,

Thank you for your letter of 7 September 2023 about the death of Sultana Choudhury. I am replying as Minister with responsibility for secondary care.

Firstly, I would like to say how saddened I was to read of the circumstances of Sultana Choudhury's death and I offer my sincere condolences to the family and loved ones. The circumstances your report describes are concerning and warrants a robust approach to prevent serious incidents of this nature in the future. I apologise for the lengthy delay in issuing a response and I am grateful to you for bringing these matters to my attention.

The key matters of concern identified in the report are, inadequate monitoring during Mrs Choudhury's admission; failure to subsequently diagnose a deteriorating situation, and the clinical decision to administer Venous Thromboembolism (VTE) prophylaxis.

In preparing this response, Departmental officials have made enquiries with NHS England and the Care Quality Commission (CQC). As I understand, the series of events following enquiries with NHS England, the Trust produced a Comprehensive Investigation Report in June 2023 to identify the cause of Mrs Choudhury's death and developed a robust action plan to share learning across the Trust. I am aware that CQC asked the Trust to provide a response outlining the mitigating actions taken to address the key matters of concern identified by the Coroner in the report.

Following this, CQC continue to monitor their progress through ongoing engagement and assessment with the Trust. I am informed that Barts Health NHS Trust has taken steps to address the concerns identified by HM Coroner, particularly the themes relating to continuity of care, monitoring, escalation and assessment of interventions, diagnostic overshadowing, and always ensuring effective communication during handover - particularly during out of hours. This includes improvement work relating

to the deteriorating patient that they have prioritised as part of their Patient Safety Incident Response Plan.

More broadly, CQC observe they are still seeing themes concerning failure to recognise or act on signs that a patient is deteriorating occurring across incidents that NHS Trusts report on. They acknowledge, and I agree that embedding and sustaining improvement requires ongoing commitment and auditing activities.

Over the last decade, we have relentlessly pursued higher patient safety standards across the NHS. Together with system partners, we will keep supporting the NHS to achieve continuous improvement in leadership and safety. This includes implementing key programmes from the first NHS Patient Safety Strategy to help create a positive safety culture and a widespread focus on reducing avoidable patient harm. Several national programmes have been rolled out under the first NHS Patient Safety Strategy, including:

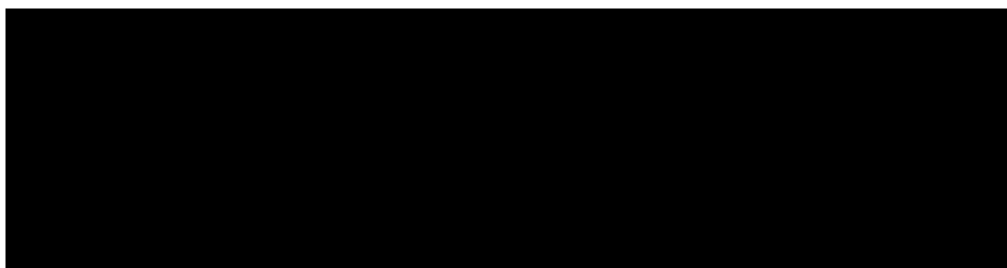
- the Learn from Patient Safety Events (LFPSE) Service to help providers learn from the 2 million patient safety events (the majority of which cause low harm) they record each year. and

- the Patient Safety Incident Response Framework (PSIRF) which represents a significant shift - and is a contractual requirement from April 2024 - in how providers respond and learn from patient safety incidents.

We are clear that hospital leaders must embed a safety culture across their organisations. This includes by ensuring key patient safety messages permeate down to staff at the workplace.

I hope this response is helpful and signifies that we are not complacent and continue to look into ways to improve patient safety and culture. Thank you for bringing these concerns to my attention.

Kind regards,



**THE RT HON ANDREW STEPHENSON CBE MP**
**MINISTER OF STATE**