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

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Department of Health & Social Care

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Peter Merchant
HM Assistant Coroner
West Yorkshire Western Coroner Area
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1st May 2024

Dear Mr Merchant,

Thank you for your Regulation 28 report to prevent future deaths dated 14/11/2023, about the death of Maxwell Frame. I am replying as Minister with responsibility for Health and Secondary Care.

Firstly, I would like to say how saddened I was to read of the circumstances of Maxwell Frame'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 significant delay in responding to this matter.

The report raises concerns over the absence of a national policy on the placement of Central Venous Catheter's (CVC). I understand that although the Trust had in place a local policy for the placement of CVC's, several doctors who gave evidence at the inquest stated that a national policy would be beneficial.

In preparing this response, Departmental officials have made enquiries with the Care Quality Commission (CQC) and the National Institute for Clinical Excellence (NICE). In their published response to your report, NICE cite existing guidance and national safety standards, including; national safety standards for invasive procedures, national CVC Insertion Safety Checklist, as well as guidance on safe vascular access (2016) which recommends the use of ultrasound locating devices for placing CVC's. The Department understands the guidance on safe vascular access is currently being updated and is due to be published in 2024. These existing standards and guidance should be used to inform local standards developed at the Trust.

Your report explains that a landmark approach was taken to the placement of Mr Frames CVC, and that a series of steps were taken which depart from existing guidance and standard practice, including the omission of an ultrasound during placement, despite being available. Your report also describes how standards were in place at the Trust for Central Venous Access Devices, which included steps that should have been taken in this case but were not.

I was deeply saddened to read of the circumstances of Mr Frame's death. The report has prompted careful reflection within my department, and from NICE and other stakeholders involved in the issuing of national clinical guidance as detailed in their responses. However, as you note in your report, the actions taken by the treating clinician departed from already existing national recommendations, NICE guidelines for administering this procedure and the Trusts own policy. I therefore do not consider there is any further action for the Department of Health and Social Care to take at this time.

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

Kind regards,

THE RT HON ANDREW STEPHENSON CBE MP
MINISTER OF STATE