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
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[redacted]

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Alison Mutch
HM Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

[redacted]

13 May 2024

Dear Ms Mutch,

Thank you for the Regulation 28 report to prevent future deaths of 1 May 2024 about the death of Mr Jordan Howarth. 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 Howarth'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.

The report raises the following concerns:

1. Whilst there was input into Mr Howarth's care from both the microbiologist and the consultant physician there was not a joint approach to his care and no detailed discussions regarding the decision to withhold antibiotics.
2. The Critical Care Outreach Practitioner had identified that Mr Howarth needed to be moved to ICU urgently, which had to be ratified by the ICU Consultant if he was to be accepted into ICU. There was no documentation from the ICU consultant setting out their rationale for not examining Mr Howarth at that point and for declining to admit him at that point.
3. The Trust's policy was that anyone who had a NEWS2 score of 5 and no ceiling of care should be referred to the Critical Care Outreach team. The inquest heard evidence that this was not followed on a number of occasions and the fact it had been missed was not identified by more senior members of the nursing team.
4. The inquest heard oral evidence of conversations that it was told had taken place between consultants in a number of specialisms about Mr Howarth that were not documented in his notes.
5. The inquest heard that despite the complexity of his case there was no evidence of a multidisciplinary discussion/approach to assess his position fully and that it was unclear who was responsible for the continuity of his care.

Most of these issues are operational in nature and I note that you have rightly sent your report to the hospital in question (Tameside General Hospital). It will be important that they consider these issues and findings fully and write to you with the actions and improvements they will be taking to address your findings and prevent a reoccurrence of what happened to Mr Howarth.

In the meantime, it may be helpful if I outline the work we are doing at a national level to improve how the NHS detects and acts upon signs of deterioration.

In February the Government and NHS England announced plans to implement Martha's Rule in at least 100 acute or specialist NHS sites in England by March 2025. Martha's Rule is an initiative that gives patients and their families who are concerned about deterioration in their physiological condition the right to initiate a rapid review of their case 24 hours a day from someone outside of their immediate care team. When requested, this rapid review will inform whether any new or additional action needs to be taken to help ensure patients receive the most appropriate care and treatment – which may include escalation.

While some NHS Trusts already offer rapid review processes similar to Martha's Rule called Call 4 Concern, others do not have an equivalent mechanism in place. In recognition of these variations in readiness, we are initiating a phased approach to implementing Martha's Rule. NHS England are leading the process of identifying the 100+ sites that will participate in this first phase and supporting the development of their local processes. Alongside this, NHS England will develop proposals for national rollout in the next Spending Review period.

Implementation of Martha's Rule forms part of NHS England's Managing Deterioration Safety Improvement Programme. This programme aims to reduce deterioration-associated harm by improving the prevention, identification, escalation and response to physical deterioration, through better system co-ordination and as part of safe and reliable pathways of care. In addition to phase one of Martha's Rule implementation, the programme consists of the following workstreams:

- Continued testing and implementation of the standardised national deterioration tools addressing adults, children and young people, maternity and newborns across settings, incorporating patient, carer and family concerns; and
- Publication, implementation and spread of the PIER Framework (**P**revent, **I**dentify, **E**scalate and **R**espond to physical deterioration), to improve how the NHS supports staff across systems to manage deterioration and encourage greater involvement from patients, families, and carers.

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

Best Wishes,

MARIA CAULFIELD