Department of Health & Social Care

From [redacted]
Parliamentary Under-Secretary of State for
Mental Health and Women's Health Strategy

39 Victoria Street
London
SW1H 0EU

Our ref: PFD – 24 – 05 – 13 – MORTON

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

By email: [redacted]

21 June 2024

Dear Mr Irvine,

Thank you for the Regulation 28 report of 13 May sent to the Department of Health and Social Care about the death of Elvon Paul Randolph Morton. I am replying as the Minister with responsibility for patient safety.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Morton'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 concerns over a lack of documentation and poor medical decision making in Mr Morton's care and failures in governance at the Trust.

In preparing this response, Departmental officials have made enquiries with NHS England. The department is advised that the matters of concern raised are primarily local and for Barts Health NHS Foundation Trust to address, who confirm they are in receipt of this report. The report provides a further opportunity for the Trust to reflect and assure itself that it has acted on all the learnings to be taken from Mr Morton's death. It is vital that lessons are learnt collectively, and changes are made to reflect where things have gone wrong, which is essential to ensure the NHS provides safe, high-quality care.

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

Yours sincerely,

[redacted]