Department of Health & Social Care

From Baroness Gillian Merron
Parliamentary Under-Secretary of State for
Patient Safety, Women's Health and Mental Health

39 Victoria Street
London
SW1H 0EU

Our ref: [redacted]

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

By email: [redacted]

3 September 2024

Dear Graeme,

Thank you for the Regulation 28 report of 4 July sent to the Department of Health and Social Care about the death of David John Morris. I am replying as the Minister for Patient Safety, Women's Health and Mental Health.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr David John Morris' death, and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention.

The report raises concerns across multiple fronts over the care provided by the Trust and its processes, in particular:

1. Mr Morris's diagnosis and treatment for cancer was delayed due to poor organisation and communication at the Trust.
2. Failure to identify the onset of Sepsis and to treat and escalate once it was diagnosed leading to delay of care before a medical review commenced emergency treatment.
3. Poor standard or lack of clinical records during ward-based treatment which impeded the investigation of this death by the Trust's governance teams and the coroner.
4. No effective review by the Trust upon how the initial serious investigation report gained executive approval as it was unfit for purpose.
5. Lack of effective controlled drug management systems in place for employees at the Trust.

In preparing this response, my officials have worked with NHS England (NHSE), the Care Quality Commission (CQC) and the Medicines & Healthcare products Regulatory Agency (MHRA) to ensure we adequately address your concerns.

I understand that the Barking, Havering & Redbridge University Trust will also be responding separately to your concerns and that the London region of NHS England is

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engaging directly with the Trust on the concerns you have rightly raised about the care provided to Mr Morris.

The CQC has confirmed that they are reviewing this case, and will consider what further action should be taken, and whether any monitoring of the trust, or regulatory response, is required.

The Chief Safety Officer at the MHRA is also providing a response to your report. And I have received assurances that they have carefully considered the concerns raised. I will not duplicate their response concerning the gastrostomy device mentioned in your report, as they are best placed to answer your concerns. As per the request from MHRA, you may wish to share the brand name and manufacturer of the gastrostomy device used on Mr Morris and MHRA will be able to check the wording in their specific product information to ensure the appropriate advice on checking for leaks is present.

I wholeheartedly agree with you regarding the importance of organisations across the health system working together to ensure effective cancer diagnosis, and I regret that this did not occur in Mr Morris' case. It is important to ensure that the issues you outlined in your report are not repeated. Thus, we will continue to work alongside NHSE and local systems to reduce waiting times and deliver on the NHS Long-Term Plan ambitions to diagnose 75% of cancers at stage 1 and 2 by 2028.

I recognise how devastating Sepsis can be, and my deepest condolences are shared with Mr Morris' loved ones. As you know, sepsis can be challenging to diagnose early as it can vary in presentation. An effective response relies on sepsis being both identified and treated rapidly, and it is critical to treat patients early with antibiotics once sepsis is suspected.

It is my understanding that to support rapid diagnosis, the National Early Warning Score (NEWS2) is used as a clinical screening and decision support tool for the recognition of acutely unwell and deteriorating patients, including those with suspected sepsis. Although NEWS2 has been implemented across 98.4% of acute trusts and 100% of ambulance trusts in England, some patients with sepsis, including Mr Morris, are still not being put onto the appropriate care pathway quickly enough. Recognising this, the National Institute for Health and Care Excellence (NICE) guidance on the recognition, diagnosis and early management of sepsis was updated in March 2024, following the publication of the Academy of Medical Royal Colleges' 'Statement on the initial antimicrobial treatment of Sepsis', in May 2022: Overview | Suspected sepsis: recognition, diagnosis and early management | Guidance | NICE. Furthermore, NICE has additional guidance under development, informed by the latest evidence. It is important that we facilitate and support a robust understanding of updated guidelines amongst a wide range of healthcare professionals.

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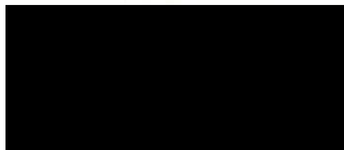
With the aim of improving our understanding of sepsis and its impacts, the Department works with NHSE and the UK Health Security Agency to monitor trends in infection incidence and deaths from sepsis, which are often complex and multifactorial issues. The National Institute for Health and Care Research (NIHR) also funds several studies into sepsis. In 2022, NIHR awarded £3.2m funding to the Sepsis Trials In Critical Care study (SepTIC), which will look to answer critical questions on sepsis diagnostics and treatment. It is our hope that continuing to improve our understanding of sepsis and how it can be better managed will improve outcomes for patients and reduce preventable deaths occurring in the future.

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,



BARONESS MERRON