Department of Health & Social Care

[redacted]
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
The Coroner's Court
Queen's Road
Walthamstow
E17 8QP

By email: [redacted]

13 September 2024

Dear Mr Irvine,

Thank you for the Regulation 28 report of 25 July sent to the Department of Health and Social Care about the death of Mrs Elizabeth Grace Holder**.** 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 Mrs Holder'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 the Barts Health NHS Foundation Trust's failure to prevent a predictable and therefore avoidable fall which resulted in death. Despite this incident activating the Patient Safety Incident Response Framework (PSIRF) at the Trust, no sub-optimal aspects to Mrs Holder's care were identified. Thus, there are concerns around the failure of the Trust's governance systems to:

a. Identify and reflect upon failings in care,
b. Consequently, the failure of the trust to act in a way to remediate the factors that contributed to Mrs Holder's death.

In preparing this response, my officials have made enquiries with NHS England and the Care Quality Commission (CQC) to ensure we adequately address your concerns.

The Barts Health NHS Foundation Trust is also a direct recipient of this report as the concerns raised relate to the failures at the Trust. I have received assurance that they will be providing a response to address your concerns. I welcome this, so we can better understand what went wrong and deaths such as Mrs Taylor's can be prevented in the future.

A key concern in your report is around the investigation conducted by the Trust and its governance processes. As you might be aware, the PSIRF became a contractual obligation for all Trusts from 1 April 2024, replacing the Serious Incident Framework (SIF).

[redacted]
Parliamentary Under-Secretary of State for
Patient Safety, Women's Health and Mental Health

39 Victoria Street
London
SW1H 0EU

PSIRF overhauls the way Trusts respond to patient safety incidents with a focus on more effective learning and engaging families. Under the SIF, hospitals were only required to investigate incidents that reached the threshold for being defined as 'serious'. This sometimes meant that other incidents were not investigated or learned from. For patients and families, the former process could be long and drawn out, and some patients reported feeling shut out from investigations. PSIRF aims to provide a more flexible, transparent and compassionate approach to learning responses and investigations, focused on understanding the different factors that contributed to incidents and ensuring organisations learn from them.

I have been informed that the CQC will be discussing the PSIRF in upcoming meetings with the Trust. The CQC also continue to monitor the Trust and will consider whether further action is appropriate or necessary. I look forward to any developments which could provide a deeper understanding of the underlying issues at the Trust and help preventing future deaths such as Mrs Holder's.

I strongly believe that working with the NHS to deliver learning from patient safety errors is crucial to changing the way patient safety is approached in the NHS.

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

Yours sincerely,

[redacted]

[redacted]