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

By email: [redacted]

22 October 2024

Dear Mr. Irvine,

Thank you for the Regulation 28 report of 30 August sent to the Secretary of State about the death of Terence Harry Clark**.** I am replying as the Minister for Patient Safety.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr. Clark'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 poor record keeping at the Trust around the decision to remove and the misplacement of the nasogastric (NG) tube the day prior to surgery – impeding the investigation. Secondly, the Trust's investigation did not identify the removal of the NG tube as a significant factor worthy of scrutiny although there was nil-by-mouth order for 24 hours prior. This raises concerns about securing and reviewing evidence relevant to governance and controls at the Trust.

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 CQC inform us that actions have taken by the Trust to address the concerns raised by the coroner. The CQC will monitor the Trust on the implementation of these actions and ensure they are embedded for the long term.

I have been assured that as direct recipient of this report, the Trust is considering the concerns carefully and will be responding at length. Appropriate governance is essential for the effective running of any organisation, and I look forward to their response to provide the detail behind the actions taken and the learning from Mr Clark's sad case. It is vital to understand the changes made so that the concerns raised in the report around Mr. Clark's death do not recur.

Patient safety is a top priority for this government and no one accessing the NHS should ever have to worry about receiving the right care and in the right hands. Several reports have identified shortcomings in the way patient safety incidents were investigated and learned from under the previous Serious Incident Framework (SIF). As you might be aware, the Patient Safety Incident Response Framework (PSIRF) replaces the SIF. It is part of the NHS Patient Safety Strategy and represents a significant shift in how providers must now respond and learn from patient safety incidents with a focus on more effective learning and engaging families.

Building an NHS fit for future is a key mission for this government. It is only with our continued and joint efforts with partners and stakeholders that we can drive improvements in safety and quality.

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

Yours sincerely,

[redacted]

[redacted]

PARLIAMENTARY UNDER-SECRETARY OF STATE FOR
PATIENT SAFETY, WOMEN'S HEALTH AND MENTAL HEALTH