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

39 Victoria Street
London SW1H 0EU

Department of Health & Social Care

Our ref: [redacted]

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

By email: [redacted]

07 January 2025

Dear Mr Irvine,

Thank you for the Regulation 28 report of 25 October sent to the Secretary of State about the death of Chloe Every. 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 Chloe's death, and I offer my sincere condolences to her family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

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 report raises concerns over several failings at the Barking, Havering & Redbridge NHS Foundation Trust (BHRUT), which are summarised below:

- Inadequate nurse cover;
- Absence of medical notes which prejudiced the inquest;
- Below par clinical observation;
- Process of informed consent and nurse CPR training;
- Governance processes failure to identify patient safety incident.

NHSE have informed us that BHRUT is preparing a response to address your concerns in full. This is entirely appropriate due to the nature of the concerns raised and as a direct recipient of this report. I look forward to their response with interest and do not wish to duplicate it. However, I will highlight some points from the information shared with us, of the actions taken to improve matters in relation to the care of patients with learning disabilities since Chloe's death in 2019:

- Daily checks are conducted by the Learning Disability Team at the Emergency Departments and the wards for any learning disability patients that are being cared for.
- BHRUT introduced the Emergency Department (ED) care pathway in June 2021, and they have an Inpatient Learning Disability Good Practice Care Pathway in place, including out of hours for both. Other resources such as safe toilet facilities, Easy Read appointment letter and guidance is also available.

- The Learning Disability & Autism Training for all staff was first implemented and mandated in January 2022 and further updated in 2024 with the government preferred Oliver McGowan Mandatory training.
- A Learning Disability Policy and a Transition Policy (the transfer from child health to adult health) is in place.
- A learning disability champion has been introduced – as a key contact for patient with learning difficulties, their families and staff.
- Crucially, structured reviews are held that provide feedback to Learning from Lives and Deaths – people with a learning disability and autistic people (LeDeR) – to improve the care and treatment of people with a learning disability in their area.
- BHRUT plan to recruit more learning disability nurses in 2025. They have created pathways to encourage and upskill existing staff due to the shortage of nurses going into learning disability training (RNLD).

I have been informed by CQC that the latest inspection from 2023 supports BHRUT's narrative on improvements made since 2019, including several changes at leadership

level, the updating of governance processes and focused support to patients with learning disabilities. The full inspection report can be viewed here: https://www.cqc.org.uk/provider/RF4/reports.

As the Minister for Patient Safety, I fully appreciate your concern around patient safety failures, which resulted in denying the court an opportunity to gather relevant evidence through autopsy. CQC acknowledge that the lateness in actions of informing the Coroner and CQC are not in line with their expectations. This will be a key point of discussion in the upcoming meeting in December where they will also focus on BHRUT's response to this report. The aim is to underpin actions to embed learning from this death, as well to ensure that people using their services are kept safe.

I understand, that BHRUT undertook a Serious Investigation review in 2019 prior to the introduction to PSIRF, alongside an Independent Investigation. As you may be aware, the Patient Safety Incident Response Framework (or PSIRF), removes the Serious Incident threshold for investigation enabling organisations to respond much faster to safety events where there's the greatest potential for learning and improvement. All NHS trusts in England have now transitioned to PSIRF and an evaluation of the implementation and impact of the framework is ongoing. Early indications suggest (aligned with the findings from the early adopter programme) that PSIRF supports more effective learning and improvement and provides the foundation for the development of an effective safety culture.

Learning lessons is essential to ensure that NHS provides the care and respect to everyone who needs it.

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

Yours sincerely,

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PATIENT SAFETY, WOMEN'S HEALTH AND MENTAL HEALTH