Barts Health
NHS Trust

Trust Headquarters
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The Royal London Hospital
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Our ref: ID508817
Your ref: 30061170

Date: 11th July 2025

Private & Confidential

East London Coroners Court
Queens Road
Walthamstow
London
E17 8QP

Dear HM Coroner,

Thank you for your letter dated 12 May 2025 following the inquest of Mr Kenneth Martin Robert Foster detailing concerns arising from the evidence presented and inviting the Trust to consider the implementation of changes to reduce the risk of future harm or death.

The Prevention of Future Death report has been reviewed at Whipps Cross Hospital (WCH) Divisional and Hospital Boards to agree actions that will have an impact across the Barts Health group. The PFD and response has been shared at Trust Safety Committee, with National Health Service England (NHSE), the Care Quality Commission (CQC) and the North East London Integrated Care Board (NELICB).

Your concerns

A failure in governance at the Trust meant this case was not identified as an incident worthy of investigation through the Patient Safety Incident Response Framework (PSIRF). This omission gives rise to concern that future deaths may follow due to an inability on the part of the Trust to identify, reflect upon and remediate sub-optimal practice.

In this case the Trust's incident reporting system, morbidity, and mortality (M&M) meeting process and Patient Safety Incident Response Meeting (PSIRM) procedure were inadequate.

Our response

The Trust deeply regret the concerns as described by HM Coroner and are sorry for the impact these will have had on Mr Foster's family.

The Trust acknowledge that Mr Foster's family raised serious concerns in their family statement about the care provided to Mr Foster during his final admission to Whipps Cross Hospital. The family concerns were investigated and responded to via the complaints process. The Trust recognise that provision of the complaint response 2 days before the inquest was unacceptable. The Trust accept that this will have contributed to the lack of assurance the family and HM Coroner were provided in relation learning and improvement that must be derived from the care and treatment provided to Mr Foster.

Since December 2024, at Whipps Cross Hospital, each new inquest opened is reported via the incident reporting system (Datix). The cases are presented at the Patient Safety Incident Response Meeting (PSIRM) and where a Mortality and Morbidity Meeting (M&M) has not yet been held, arrangements are made to expedite this process to inform decision making around the type of learning response required in accordance with the Patient Safety Incident Response Plan.

The M&M for Mr Foster was undertaken on 30 December 2024, the documentation indicates that his care was graded (according to the National Confidential Enquiry into Perioperative Deaths) as an outcome 'A', indicating a good standard of care. It should be noted that this meeting took place before the family concerns were submitted. The Patient Safety Incident Response Meeting took place on 14 February 2025 (following confirmation that an inquest had been opened. The meeting attendees relied on the M&M and Structured Judgment Review (SJR) findings and determined that the case did not meet the criteria (according to the hospital Patient Safety Incident Response Plan) for a learning response to be commissioned.

Whipps Cross Hospital, having reviewed the case again as part of the response to this PFD now consider that the case could have been brought back to the Patient Safety Incident Response Meeting when the family's complaint was submitted. Taking into consideration the family complaint, which detailed a number of concerns around, basic care, communication, nutritional support, and medication the NCEPOD grading could be revised to outcome 'C' indicating a need for improvement. Whilst a Patient Safety Incident Investigation (PSII) may not have been indicated, it is clear, in retrospect that further investigation should have been considered e.g. After Action Review (AAR) or Multi-Disciplinary Team (MDT) review. The complaint investigation should have been provided sooner and could have contained more assurance around learning and improvement in response to the findings from the complaints investigatory process.

As part of the learning from this PFD, the Whipps Cross Hospital Senior Leadership Team will ensure that families are contacted as part of the Patient Safety Incident Review Meeting (PSIRM) process to ensure that a more robust review is undertaken. Taking account of family concerns should be a key aspect to inform decision making around the level of investigation required. This action will also ensure reviews include the views of the patient's family, in line with Patient Safety Incident Response Framework (PSIRF) compassionate engagement principles.

In order to gain additional assurance, the Trust has commissioned a review to be undertaken by a specialist within the North London Integrated Care Board and supported by NHSE to review

the governance processes relating to this case. The review will be completed by the end of August 2025 and the outcome will be shared with HM Coroner. An integral part of this review will be engaging with the Foster family to understand their experience of the governance process. The learning from this review will have implications, not only from Whipps Cross Hospital but for the Barts Health group.

Whipps Cross Hospital teams are committed to preventing avoidable harm to patients and would like to thank the Foster family and HM Coroner for highlighting a gap in governance processes. We are committed to learning from this and making improvements. We hope that this response provides assurance around the actions that will be completed and monitored to effect improvement in response to this PFD.

If you have any queries, please do not hesitate to contact me.

Yours sincerely

[redacted]
Group Chief Medical Officer
Barts Health NHS Trust