Department of Health & Social Care

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

39 Victoria Street
London SW1H 0EU

Our ref: PFD – 25-05-12 - FOSTER

HM Coroner Mr Graeme Irvine
124 Queens Road,
Walthamstow,
E17 8QP

By email: coroner@walthamforest.gov.uk

21st August 2025

Dear Mr Irvine,

Thank you for the Regulation 28 report of 12 May 2025 sent to the Secretary of State for Health and Social Care about the death of Kenneth Foster. I am replying as the Minister with responsibility for patient safety.

Firstly, I would like to say how saddened I was to read about the circumstances of Mr Foster's death and I offer my sincere condolences to his family and loved ones. I am grateful to you for bringing your issues of concern to my attention.

Your report raises a concern that Mr Foster's death was not identified as an incident that warranted an investigation by Barts Health NHS Foundation Trust under the Patient Safety Incident Response Framework (PSIRF).

In preparing this response, my officials made enquiries with NHS England's National Patient Safety Team to ensure that I can adequately address your concerns.

The PSIRF, introduced in August 2022, promotes four core principles to inform learning from safety events: compassionate engagement, systems-based learning, proportionate responses and supportive oversight.

While PSIRF represents a significant improvement to the way that the NHS responds to patient safety incidents, PSIRF does not alter the requirements set out in the National Learning from Deaths policy framework. These require a patient safety incident investigation to be undertaken into any event where problems in care are thought more likely than not to have led to the death of a patient.

Judging whether a death has more likely than not been caused by a patient safety incident is not always straightforward. In many cases it can be reasonable to believe that even when a patient safety incident has occurred in a patient's care, that incident did not lead to the patient's death. Due to the complexities of healthcare, there can be situations where different people can hold reasonable but opposite views about the same case.

There will also be many cases where death occurs, and no significant patient safety incidents have occurred at all.

As such, under PSIRF, not all deaths will be investigated. This will include some which go to inquest. Decision-making regarding patient safety incident response should be documented by Trusts as part of a robust governance process. Where a specific learning response is not undertaken in relation to an incident discussed at inquest, the organisation should be able to explain why this was the case.

Nonetheless, I note that you have also sought a response from the Chief Executive Officer of the Trust, [redacted] and have now received a response from [redacted], Group Chief Medical Officer at the Trust.

The Trust has stated, in light of the concerns your report has raised, North London Integrated Care Board, supported by NHS England will review the governance processes relating to Mr Foster's case to see where improvements can be made and where the Trust can learn from the gaps in its governance, identified by your coroner's report.

The Trust have stated that the review will be completed by August 2025 and shared with you.

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

All good wishes,

[redacted]

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