Department of Health & Social Care

[redacted]
Parliamentary Under-Secretary of State for Health Innovation and Safety

39 Victoria Street
London
SW1H 0EU

Mr Christopher Murray
HM Assistant Coroner
Manchester South Coronial Area
1 Mount Tabor Street
Stockport SK1 3AG

[redacted]

22 October 2025

Dear Mr Murray,

Thank you for the Regulation 28 report of 2 July 2025 sent to the Secretary of State for Health and Social Care about the death of Neil John Clarke. I am replying as the recently appointed new Minister with responsibility for Patient Safety.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Clarke's death, and I offer my sincere condolences to their family and loved ones. I am grateful to you for bringing these matters to my attention. Please accept the department's apologies for the delay in responding to this matter.

I understand NHS England have responded to you separately. I also understand, Stockport NHS Foundation Trust have also responded to you.

The first concern you raised in your report relates to considerations given to the appropriateness, from a safety and well-being perspective, of surgical procedures involving elderly patients.

You will be aware; from the response you received from NHS England that there is clear national guidance on perioperative care for both adults and specifically older people from the National Institute for Health and Care Excellence (NICE) and the British Geriatrics Society (BGS). NHS England has also undertaken considerable work to develop guidance on Early screening, triaging, risk assessment and health optimisation in perioperative pathways. This includes information on risk assessment and shared decision making. In response to your first concern, I am assured that Stockport NHS Foundation Trust have taken steps to improve information and training relating to shared decision making and consent. In July this year the Trust rolled out a mandatory training programme that all clinical staff delivering patient care are required to be enrolled on. Compliance to this training requirement is being reported through a governance process.

Your second concern relates to the accuracy of handover communications between clinical staff in respect of patients returning to the main ward from the High Dependency Unit. You will be aware that prior to the inquest into the death of Mr Clarke, that the Trust's Divisional

Nursing Director, together with senior nursing staff have implemented and continue to embed changes to the discharge process throughout the Division of Surgery and the wider Trust. These included updating the process to the discharge checklist completed by ICU/HDU staff for a patient transferred to a main ward and a joint handover process. The Trust has audited this updated approach to ensure it is fit for purpose and will continue to monitor it.

The Government is prioritising patient safety and a learning culture in the NHS, to minimise harmful events but we also acknowledge that it is not realistic to eliminate all complications in patients undergoing life saving high risk surgery even when all reasonable mitigations are in place.

The changes being made as part of the 10-year Health Plan and [redacted] report on the patient safety landscape will improve quality and thereby system safety by making it clear where responsibility and accountability sits at all levels of the system.

To drive improvements in patient safety, we will usher in a new era of transparency, a rigorous focus on high-quality care and a renewed focus on patient and staff voice.

Over recent years, the NHS has made significant strides to improve patient safety, including implementing key programmes under the NHS Patient Safety Strategy (2019). The Strategy is now achieving its aim of saving around 1000 lives per year and £100m in care costs per year.

Measures we have taken over the last year include:

- Roll out of Martha's Rule, which is now being expanded to all acute inpatient sites. From September 2024 to July 2025 more than 260 Martha's Rule escalation calls required transfers of care to high dependency or intensive care units, enhanced levels of care or to tertiary centres.
- implementing medical examiners on a statutory basis to scrutinise all deaths that are not investigated by a coroner, in order to facilitate learning and improvement locally.

The Care Quality Commission is also rebuilding its regulatory approach via a data-driven, intelligence-led model to enable the regulator to have a more rounded understanding of the service quality and safety Trusts are delivering.

These changes will ensure the safety and learning cultures across the NHS are more consistent.

Thank you for bringing your concerns to my attention.

Yours sincerely,

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for Health Innovation and Safety