Department of Health & Social Care

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

39 Victoria Street
London
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[redacted]

Mr G Irvine – Senior Coroner
East London Coroner's Court
124 Queens Road Walthamstow,
E17 8QP

[redacted]

19th December 2025

Dear Mr G Irvine,

Thank you for the Regulation 28 report of 23 September 2025 sent to the Secretary of State for Health and Social Care about the death of Tony Buengo Jackson**.** I am replying as the Minister with responsibility for patient safety.

I would like to start by saying how saddened I was to read of the circumstances of Mr Jackson's death, and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention. Please accept my apologies for the delay in responding to this matter and thank you for the additional time provided to the department to provide a response to the concerns raised in the report.

The report raises concerns about the care received by Mr Jackson at Newham Hospital relating to the following points: -

- A fatal iatrogenic injury sustained by Mr Jackson on 19th November 2024 went undetected until 3rd December 2024, despite admission, a CT scan and surgical consultation on 24th November 2024.
- Records of, best interest decisions, the Percutaneous Endoscopic Gastrostomy insertion and subsequent treatment were so poor as to impede the court's investigation.
- The Trust could not provide notes of the 24th November admission.
- A failure in governance at the Trust meant that this case was not identified as an incident worthy of investigation through the Patient Safety Incident Response Framework (PSIRF). This omission gives rise to a 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 Datix incident reporting system, morbidity and mortality meeting process and PSIRF procedure were inadequate.

In preparing this response, my officials have made enquiries with NHS England and the Care Quality Commission (CQC) to ensure that we adequately address your concerns.

NHS England have assured me that all coroner cases at Barts Health NHS Foundation Trust will be discussed at the multi-disciplinary team patient safety event meeting chaired by the Director of Nursing, Medical Director or Divisional Medical Director and attended by each speciality to reduce the likelihood of lack of awareness of patient safety incidents caused in one service but presenting in another.

Following receipt in September of your Prevention of Future Death (PFD) report relating to Mr Jackson, CQC engaged with the leadership team at Newham Hospital, and I believe is now assessing the Trust's full response to the report CQC have assured me that it will keep monitoring progress and improvement at the hospital and Trust as part of their ongoing engagement.

Regarding the concerns about application of the PSIRF, the Trust is reviewing the mortality and morbidity process across the hospital to ensure better alignment with learning and improvement systems. CQC have raised concerns with the Trust that there is disparity in the effective application of PSIRF across the different hospital's governance teams. The CQC will review the Trust's response and decide if any further action is needed.

The Government is committed to fostering a learning culture in the NHS, to minimise harmful events however we also acknowledge that it is not realistic to eliminate all complications in patients undergoing lifesaving 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 are ushering 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 CQC 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.

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

Yours sincerely,

Parliamentary Under-Secretary of State
for Health Innovation and Safety