NHS
Barts Health
NHS Trust

Trust Headquarters
Executive Offices
Ground Floor
Pathology and Pharmacy Building
The Royal London Hospital
80 Newark Street
London
E1 2ES

[redacted]

Date: 30 April 2026

Private & Confidential

East London Coroners Court
Queens Road
Walthamstow
London
E17 8QP

Dear HM Coroner,

The Trust is grateful for the concerns you have raised in relation to the death of Mr Ioannou and welcomes the opportunity to reflect openly on the issues identified. We would like, first and foremost, to express our sincere apologies that the Trust did not undertake an investigation under NHS England's Patient Safety Framework, and for the distress this omission may cause to the family and all those affected.

With the benefit of hindsight, the Trust accepts that Mr Ioannou's death should have been subject to a formal patient safety investigation. Despite a post-mortem examination being undertaken, there remained uncertainty regarding both the aetiology and the precise timing of the fatal infection. It is now clear that this uncertainty warranted a more structured and detailed investigation to explore whether a pre-existing infection may not have been identified at the time of treatment on 23 June 2025, or whether there was any possibility that the treatment itself contributed to the subsequent infection. We acknowledge that, within a robust clinical governance framework, these possibilities ought to have been fully examined.

The Trust also recognises the particular importance of enhanced scrutiny where care is delivered to patients with profound learning disabilities. We accept that communication difficulties may have affected the quality of care provided and that the absence of a formal investigation represents a missed opportunity for organisational learning. The Trust agrees that cases involving patients who may not be able to articulate symptoms or concerns require heightened awareness, stronger advocacy, and a clear escalation route when deterioration is suspected.

In response to the issues identified, the Trust has taken the following actions and provides the following assurances:



- Thresholds for initiating investigations under the Patient Safety Framework have been reinforced across clinical services, with explicit emphasis on deaths involving diagnostic uncertainty
- Additional training has been provided to clinical staff on recognising when uncertainty itself constitutes a trigger for investigation.
- Oversight arrangements have been strengthened to ensure that decisions not to investigate are reviewed and clearly documented, with senior sign-off where appropriate.

The Trust is committed to ensuring that the learning from this case informs future practice and strengthens our patient safety arrangements. We are deeply sorry that these steps were not taken at the time of Mr Ioannou's death and regret the impact this may have had on the family's confidence in our processes.

We are grateful to HM Coroner for highlighting these concerns and for the opportunity to demonstrate our commitment to improvement, transparency, and learning.
If you have any queries, please do not hesitate to contact me.

Yours sincerely

[redacted]

[redacted]
Group Chief Medical Officer
Barts Health NHS Trust

