Department of Health & Social Care

[redacted]
*Parliamentary Under-Secretary of State*

*39 Victoria Street*
*London*
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[redacted]
HM Coroner Graeme Irvine
East London Coroner's Court,
Queens Road,
Walthamstow,
E17 8QP

[redacted]

1st June 2026

Dear Mr Irvine,

Thank you for the Regulation 28 report of 10 March 2026 sent to the Secretary of State of Health and Social Care about the death of Sheila Creegan. I am replying as the Minister with responsibility for Patient Safety.

Firstly, I would like to say how saddened I was to read of the circumstances of Mrs Creegan's death, and I offer my sincere condolences to their 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 sincere apologies for the delay in responding to this matter.

The report raises concerns over use of Patient Safety Incident Response Framework (PSIRF) process and the circumstances of Mrs Creegan's care, these include: -

- The inaccurate cause of death initially offered by the Trust,
- The failure to investigate the seat of Mrs Creegan's burgeoning infection after her pneumonia resolved,
- The missed diagnosis of infective endocarditis,
- The failure to monitor the development of Mrs Creegan's heart failure during her inpatient treatment.

In preparing this response, my officials have made enquiries with NHS England and the Care Quality Commission (CQC) to ensure we adequately address your concerns on PSIRF. I note you have also copied your report to Barking, Havering, and Redbridge University Hospitals NHS Trust (BHRUT) who will respond to the broader concerns you have raised.

The Patient Safety Incident Response Framework, 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 Learning from Deaths Framework. This includes the requirement for a patient safety incident investigation to be undertaken into an 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 entirely reasonable but differing views about the same case. There will also be cases where death occurs, and no significant patient safety incidents have occurred. Consequently, not all deaths will be investigated. This will include some which go to inquest.

Decision-making regarding the type of response required following a patient death should be documented 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. Specific questions to support the inquest should be considered outside of the learning response process.

It is my understanding that BHRUT have had ongoing conversation with HM Coroner's regarding its application of the PSIRF model.

The CQC have also engaged with BHRUT in October 2025 where PSIRF was discussed. BHRUT reported "good progress" with PSIRF, updating CQC that they are now comfortable with the process and more confident in prioritising incidents that add the most value for learning. During this engagement meeting, BHRUT offered CQC assurances on their after-action review (AAR) practice, early examples of impactful multidisciplinary team learning, and evidence of improved decision making with less professional resistance.

BHRUT informed CQC that embedding learning into sustained improvement is the next key area of focus and is strengthening links with Quality Improvement and strategic planning to support this.

CQC plan to follow up on actions/progress cited by the trust from their October 2025 update when they next engage with BHRUT; CQC have also requested a copy of the trust's response to this PFD and will review this and determine if any further follow up action with the trust is needed.

CQC also understand that BHRUT are piloting and evaluating a more proactive and structured approach to Coroner engagement, which has been introduced through a Coroner's Care Review Meeting. CQC will request information about this pilot and future plans by the trust for Coroner engagement when they next meet with them.

CQC continue to monitor BHRUT and the services they provide to people to ensure appropriate regulatory oversight.

I hope this response is helpful. Thank you for bringing these concerns to my attention. I am committed to improving patient safety and it remains at the heart of our health service.

Yours sincerely,

**PARLIAMENTARY UNDER-SECRETARY OF STATE**
**FOR HEALTH INNOVATION AND SAFETY**