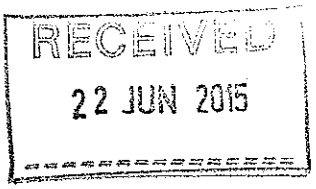
From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Department
of Health

Your Ref: RWH/DS/906/13



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Dr Robert W Hunter
Senior Coroner, Derby and Derbyshire Coroner's Area
Coroner's Court
5-6 Royal Court
Basil Close
Chesterfield S41 7SL

17 JUN 2015

Dear Dr. Hunter,

Thank you for your letter of 19 May enclosing the Regulation 28 Report on the inquest into the death of Sheila Johnson.

I share your concern following your comments on the lack of co-operation by the Tameside Hospital NHS Foundation Trust. Departmental officials have made enquiries with the Trust, and I have been assured that it will be responding appropriately to your Regulation 28 Report.

Officials have shared your letter with the Care Quality Commission (CQC). The CQC advises that it will follow up any actions identified as a result of the Trust's response as part of its ongoing engagement with the Trust. The CQC will also reinforce the duties of the Trust in relation to its duty of candour and being open, transparent and cooperative with key stakeholders and statutory bodies.

You are right that improving transparency and reinforcing a culture of openness and honesty is a key focus for the NHS and it is crucial that NHS trusts meet expectations in this area. The fundamental standards require that providers assess, monitor and improve the quality and safety of services. The CQC's guidance about complying with this regulation, to which all providers must have regard, states that providers should share relevant information. This would include sharing information about incidents with relevant bodies, including coroners.

In addition, the CQC has a number of actions in hand that are intended to improve working between healthcare providers and coroners, including the establishment of a Memorandum of Understanding with the Coroners Society of England and Wales to

achieve better working relationships and improve the sharing of information, as well as developing a single protocol for handling information from coroners, which includes storing and passing on information.

You will also be aware that there is existing legislation in relation to how public bodies and professionals should behave with respect to coronial processes.

Finally, you may be aware that one of the recommendations made by [redacted] in his report into the deaths of mothers and babies at the University Hospitals of Morecambe Bay NHS Foundation Trust was around the setting out of duties of all NHS trusts and their staff in relation to inquests. The Government hopes to respond formally and fully to the Morecambe Bay investigation recommendations shortly, which may be of interest to you. While I am not able at this point to give an indication of the Government's response to the recommendations, I hope you will be assured that we are giving thought to whether further measures are required to guide appropriate behaviour in relation to coroner investigations and inquests.

I have also copied your letter to Monitor, as the Foundation Trust sector regulator for health services in England, so it is aware of your concerns in relation to Tameside.

I hope this reply is helpful.

Yours sincerely

[redacted]

JEREMY HUNT