Department of Health & Social Care

From Nadine Dorries MP
Parliamentary Under Secretary of State for Patient Safety, Suicide Prevention and Mental Health

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Your Ref: 01562-2018
Our Ref: PFD-1194553

Dr Andrew Harris
HM Senior Coroner, London Inner South
HM Coroners Court
1 Tennis Street
Southwark
London SE1 1YD

24 March 2020

Dear Mr Harris,

Thank you for your letter of 16 October 2019 to Matt Hancock about the death of Mr Derek Weaver. I am replying as Minister with responsibility for patient safety and I apologise for the delay in replying.

Firstly, I would like to say how saddened I was to read the circumstances of Mr Weaver's death and I extend my sympathies to his family and loved ones.

We must do all we can to ensure that the NHS provides high-quality, safe services and taking the learnings from incidents, such as the sad death of Mr Weaver, is key to ensure necessary improvements are made and future deaths are prevented.

Departmental officials have worked with NHS England and NHS Improvement (NHSEI), which is responding separately to your report, to prepare this response.

I am advised that NHS England's national Specialised Commissioning Quality Team has undertaken peer review and surveillance activities of thoracic services in London, including at the Guy's and St Thomas's NHS Foundation Trust where no serious quality or safety concerns were identified. I am further advised that NHSEI will maintain oversight to ensure patients requiring thoracic surgery can access the service in a timely way, according to their clinical condition. This will include reviews of bed capacity in response to the ambition set out in the NHS Long Term Plan, for earlier and faster diagnosis of cancer[1] and the impact this might have on related services such as critical care beds.

I am aware that the Guys and St Thomas' NHS Foundation Trust has responded to your report with information on the measures it has taken to improve the triage and management of patient transfers and referrals so that they are clinically prioritised. I also

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[1] https://www.england.nhs.uk/cancer/strategy/

understand that the Trust is looking to increase the bed capacity of its Thoracic Surgery Unit to better meet the needs of patients.

Finally, I note from your report that it took several months to receive medical records and other material from the East Sussex Healthcare NHS Trust. While I do not know the circumstances in this case, I want to provide assurance that NHS trusts have a legal duty of candour[2] to act in an open and honest way when there are investigations into the death of a patient in their care, as well as legal duties to provide all relevant information to support coronial processes. This was reinforced in a communication by NHS Improvement to NHS trusts in 2016[3].

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

NADINE DORRIES

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[2] https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour#full-regulation

[3] https://improvement.nhs.uk/resources/duties-relating-coroner-inquests/