Department of Health & Social Care

From Nadine Dorries MP
Minister of State for Patient Safety,
Suicide Prevention and Mental Health

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Mr Graeme Irvine
HM Area Coroner, East London
Walthamstow Coroners Court
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19 March 2021

Dear Mr Irvine

Thank you for your letter of 21 December 2020 about the death of Evadney Dawkins. I am replying as Minister with responsibility for hospital care quality and patient safety and I am grateful for the additional time in which to do so.

Firstly, I would like to say how very sorry I was to read of the circumstances of Mrs Dawkins death and I offer my heartfelt condolences to her family and loved ones.

Your report raises matters of concern relating to the failure to adequately monitor Mrs Dawkins renal function when she was admitted to the Newham University Hospital (part of the Barts Health NHS Trust); and that the Trust's governance systems did not identify what happened to Mrs Dawkins as a Serious Incident, requiring investigation.

In preparing this response, my officials have made enquiries with NHS England and NHS Improvement (NHSEI), to understand the action taken locally, and the National Institute for Health and Care Excellence (NICE), to understand the guidance that is available to support healthcare professionals to prevent, identify and respond to acute kidney injury.

I am advised that the Trust has taken learnings from Mrs Dawkins death and is confident that the changes it has implemented and planned will significantly minimise the risk of recurrence.

You will be aware from the Trust's response that it has taken measures to support nurse training in renal monitoring and recognition and treatment of deteriorating patients; improve the accuracy and accessibility of patient records through an electronic records system; and, improve arrangements for patient handover and consultant ward rounds, among other actions.

I understand the Trust has acknowledged the failure to identify Mrs Dawkins death as a Serious Incident but that it considers that it now has systems in place that mean this is unlikely to happen again. For example, the Trust advises that a multi-disciplinary team now considers unexpected deaths to determine whether investigation under the Serious Incident Review process is appropriate. Additionally, the Trust has appointed three Medical Examiners who review every death within the Trust's services. As you will know, medical examiners have been introduced to the NHS nationally to provide a new level of independent scrutiny of deaths. Furthermore, the Trust has created a new post of Deputy Medical Director with a remit to provide greater assurance on patient safety governance.

I am encouraged by the Trust's actions and I am assured by the Care Quality Commission (the CQC), the independent regulator of quality, that it has followed up your report with the Trust, seeking assurances that it has taken action to address the concerns you have raised and minimise any risk to patients.

It is of course essential to patient safety that NHS Trusts review, investigate and learn from deaths thought to be due to problems in care. That is why, in 2017, the National Quality Board published national guidance on Learning from Deaths[1], to introduce a more standardised approach.

From 2017-18, we have required NHS trusts to publish locally the numbers of deaths thought to be due to problems in care on a quarterly basis, and to evidence what they have learned and the actions taken to prevent such deaths on an annual basis in their Quality Accounts. This new level of transparency is fundamental to a culture of learning and ensuring the safety of NHS services. This policy is supported by strengthened inspection assessment of NHS trust's learning from deaths by the CQC.

You may also be interested to note that a new Patient Safety Incident Response Framework[2], to replace the Serious Incident Framework, is being developed to facilitate examination of a wider range of patient safety incidents in the NHS and to improve the quality of patient safety incident investigation and how organisations can learn and change as a result.

The Framework outlines how NHS organisations should respond to patient safety incidents, including how and when an investigation should be conducted. The Framework supports a systematic, compassionate and proficient response; anchored in the principles of openness, fair accountability, learning and continuous improvement. NHSEI is currently working with early adopters to pilot the new Framework and the learning from this pilot will be used to inform the final version of the Framework.

Finally, you may wish to note that since the death of Mrs Dawkins in 2018, the NICE has published guidance on *Acute kidney injury: prevention, detection and management* (NG148[3], published December 2019). The guideline covers prevention, detection and

[1] https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

[2] https://www.england.nhs.uk/patient-safety/incident-response-framework/

[3] Overview | Acute kidney injury: prevention, detection and management | Guidance | NICE

management of acute kidney injury in children, young people and adults and is relevant to all settings where NHS funded care is provided.

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

NADINE DORRIES
MINISTER OF STATE FOR PATIENT SAFETY, SUICIDE PREVENTION AND MENTAL HEALTH