

**From:** Do Not Reply <donotreply@dh.gsi.gov.uk>  
**Subject:** Your recent correspondence to Jeremy Hunt  
**Date:** 10 October 2017 at 15:33:57 BST  
**To:** "Alexander, Minh" <\*\*\*\*\* >

Our ref: DE-1096208

Dear Dr Alexander,

Thank you for your correspondence of 29 August to Jeremy Hunt about the Department and the NHS's handling of reports issued by coroners to prevent future deaths. Thank you also for copying to Mr Hunt your email of 27 August to Sir David Behan, Chief Executive of the Care Quality Commission (CQC) on similar matters. I have been asked to reply and I apologise for the delay in doing so.

I understand the CQC responded to your email on 29 September. The CQC processed your correspondence as a request under the Freedom of Information Act 2000. The Department considered this course of action but determined that, given the likelihood that exemptions would apply, replying in this manner would enable a fuller reply.

As you are aware, under the *Coroners (Investigations) Regulations 2013*, part 7, *Action to prevent future deaths*, available at [www.legislation.gov.uk/ukxi/2013/1629/part/7/made](http://www.legislation.gov.uk/ukxi/2013/1629/part/7/made), coroners may make recommendations in a *Report on Action to Prevent Future Deaths* (PFD) following an inquest, to a person he or she considers may be able to take action to prevent or reduce the risk of future deaths.

Recipients of PFD reports are under a statutory duty to respond within 56 days, explaining what, if any, action they propose to take, or saying why they do not propose to take any action.

Under the Regulations, coroners must send the report, and the responses they receive, to the Chief Coroner. The Regulations state that the Chief Coroner may publish a copy of the report, or a summary of it, and, a copy of the response(s) to the report, or a summary, in such a manner as the Chief Coroner thinks fit. It is therefore for the Chief Coroner to determine the appropriate format for publication of this material and the Department would not wish to undermine this

process. The nature of these reports is clearly sensitive, particularly for the bereaved families involved.

As publication of the reports is a matter for the Chief Coroner, you have taken appropriate action in addressing your concerns to his office, and I hope you receive a response soon if you have not already done so. Any wider representations you wish to make on the Regulations would be a matter for the Ministry of Justice. You may therefore wish to contact it at:

Ministry of Justice  
102 Petty France  
London SW1H 9AJ

Telephone: 020 3334 3555

Webform: <https://contact-moj.dsd.io/>

As the process for the publication of this material is outside the Department's remit, the Department will not provide copies of the responses to the reports you specifically highlighted, nor the details of all the reports to which the Department has responded, which in any case would involve considerable resource. However, I can confirm that the Department is not aware of any outstanding responses to such reports, outside those that are currently being actioned within deadlines agreed with coroners. Manual interrogation of files dating back to 2013 to determine if representations have been made by the Department to coroners not to publish any of its responses, in full or in part, would involve considerable resource. I can confirm that officials are not aware of any such instances.

I would point out that there are a number of variable factors to bear in mind when attempting to draw conclusions from the material published online. For example, it is a matter for individual coroners to determine if, and when, a report on action to prevent future deaths should be made, and to whom. It may be the case that some coroners utilise this tool more than others, meaning that discerning any notable themes or patterns, such as commonly featured NHS trusts, can lead to misleading conclusions.

Nevertheless, the Department recognises the valuable role the reports play in drawing matters of concern to the attention of the Government, its agencies and others to determine if action should be taken to prevent further deaths.

I can confirm that the Department does not conduct central analysis of prevention of future deaths reports where matters of concern are raised relating to the health and care sectors. However, the Department will ensure that the relevant regulators and other bodies are made aware of the matters of concern brought to its attention so that the system can respond as appropriate.

In responding to reports on action to prevent future deaths, the Department often looks to the advice of the 27 agencies and public bodies which support the health and care system in England. Where matters of concern involve several agencies, the Department will take a lead co-ordinating role to determine the system response. However, it will be for the responsible bodies to take forward any action identified as necessary.

I appreciate that the matters you raise are prompted by a concern for patient safety and I can assure you that the Department takes very seriously its statutory duty to respond to reports on the prevention of future deaths. The value of the reports is clearly recognised and they play an important role in bringing serious matters of concern to the attention of the appropriate bodies that have the ability to take action to prevent avoidable harm.

Learning lessons where things have gone wrong is essential to ensuring the NHS provides safe, high quality care, and responding effectively to matters brought to its attention through the inquest process, is an important part of this.

The Department is taking forward a national programme with system partners to support NHS trusts to improve the way they learn from the deaths of people who were in their care. This responds to the recommendations in the CQC's report of December 2016, *Learning, candour and accountability: A review of the way NHS trusts review and investigate deaths of patients in England*. This report is available at:

[www.cqc.org.uk/content/learning-candour-and-accountability](http://www.cqc.org.uk/content/learning-candour-and-accountability)

In March, the National Quality Board responded to one of the highest priority recommendations by publishing *National Guidance on Learning from Deaths*, which is available at:

[www.improvement.nhs.uk/resources/learning-deaths-nhs-national-guidance](http://www.improvement.nhs.uk/resources/learning-deaths-nhs-national-guidance)

The guidance provides a national framework for trusts on identifying, reviewing, investigating and learning from deaths. It also places an important emphasis upon the need for Trusts to be open with bereaved families and involve them appropriately in any investigation.

Additionally, the guidance describes a requirement for trusts to publish on a quarterly basis from 2017/18 specified information on their deaths, for both adults and children, including estimates of those deaths assessed as more likely than not to have been due to problems in care. The requirements will be underpinned by forthcoming regulations. From June 2018, the regulations will also require trusts to publish evidence of learning and improvements that are happening as a result of their quarterly data in their annual Quality Accounts.

These measures are about supporting trusts to identify and act on systemic or other problems that could contribute to patient harm. The Department is clear that NHS providers must be more willing to admit to and learn from mistakes so that they can reduce future risks to patients and avoid tragedies occurring in the first place, which is what everyone who relies on NHS services wants.

I hope this greater transparency offers some assurance that the Department is taking action to support the NHS as it looks to strengthen learning from deaths.

I hope this reply is helpful.

Yours sincerely,

Holly Casson  
Ministerial Correspondence and Public Enquiries  
Department of Health

---

Please do not reply to this email. To contact the Department of Health, please visit the [Contact DH section](#) on Gov.uk

To receive news about DH: [sign up to our monthly newsletter](#)

BY EMAIL

Rt Hon Jeremy Hunt  
Secretary of State  
Department of Health

29 August 2017

Dear Mr Hunt,

**The Department of Health's and the NHS' handling of coroners' Section 28 reports on action to prevent future deaths**

I have reviewed published coroners' Section 28 reports and have a number of questions and requests to make of you.

This published report summarises the data that I collated and links to the data itself:

<https://minhalexander.com/2017/08/24/four-years-of-published-coroners-section-28-reports-in-england-and-wales/>

I found 172 published Section 28 reports that had been sent to the Department of Health as a named respondent for action to prevent future deaths, for which there were no published responses in 60 cases.

100 of the 172 Section 28 reports sent to the Department of Health for action to prevent future deaths were addressed to you personally. There were no published responses to 45 of these Section 28 reports.

Please may I ask for the following data:

- 1) What data does the DH hold centrally on Section 28 reports? What fields feature in the DH's database?
- 2) If the DH holds the information centrally, how many Section 28 reports has it received since Section 28 reports were introduced in 2013, to what issues and NHS bodies have these Section 28 reports related, and what action has the DH taken in response to these Section 28 reports?

If the above data is held, please provide it in the form of a spreadsheet, and if the data is centrally held and it is practicable to do so please include the names of the deceased, the coroner's case reference numbers and dates of the Section 28 reports.

- 3) Does the DH hold central data on the number of Section 28 reports that have led to a system wide alert being issued? If so, please provide details of any such alerts, and please in particular include alerts issued via the DH's Central Alerting System.
- 4) Please can the DH provide me with a copy of its response to these particular Section 28 reports (I checked again today and the DH

responses have still not been published by the Chief Coroner, assuming responses were issued by the DH):

Death of Kevin Dermott in custody with contributory neglect

<https://www.judiciary.gov.uk/publications/kevin-dermott/>

Death of Nathaniel Phillips who could not afford asthma medication

<https://www.judiciary.gov.uk/publications/nathaniel-phillips/>

Death of Robert Hogg due to sepsis related to NHS 111 services

<https://www.judiciary.gov.uk/publications/robert-hogg/>

Death of Elizabeth Lester relating to flawed ambulance algorithms

<https://www.judiciary.gov.uk/publications/elizabeth-lester/>

Death of Paul Murray with contributory ambulance delay

<https://www.judiciary.gov.uk/publications/paul-murray/>

Death of Peter Scott after ambulance delay

<https://www.judiciary.gov.uk/publications/peter-scott/>

Death of Constance Pridmore under UHMBT

<https://www.judiciary.gov.uk/wp-content/uploads/2017/03/Pridmore-2016-0491.pdf>

Death of George Taylor under Cornwall Partnership NHSFT

<https://www.judiciary.gov.uk/publications/george-taylor/>

-

Death of Mary Fenton and concerns about the national pharmaceutical supply chain

<https://www.judiciary.gov.uk/publications/mary-fenton/>

-

-

- 5) Has the DH asked the Chief Coroner not to publish any of its responses to Section 28 reports, and if so, on how many occasions has the DH done so? If the DH has asked for any of its responses not to be published, what were the reasons and can the DH share the correspondence in which it asked the Chief Coroner not to publish its responses?
  
- 6) Has the DH or any of its arms length bodies conducted any central analysis of Section 28 reports and if so, what analyses have been conducted and can the DH disclose any such analyses that it holds?

I have some requests to make of you:

- 7) In the interests of setting an example on accountability and transparency, can the DH publish all its responses to coroners' Section 28 reports on action to prevent future deaths that have been received to date, and all future responses to Section 28 reports?

- 8) Can the DH make it NHS policy for all Section 28 report responses by all NHS bodies to be published in future?
  
- 9) Can the DH make it NHS policy for all NHS bodies to provide information in their annual reports on Section 28 reports received and their responses to Section 28 reports?

Yours sincerely,

Dr Minh Alexander

Cc Public Accounts Committee

Health Committee

Public Administration and Constitutional Affairs Committee

Sir Amyas Morse NAO

Sir Robert Francis CQC NED

Lord Bew CSPL