From: **Do Not Reply** donotreply@dh.gsi.gov.uk
Subject: Your recent correspondence to Jeremy Hunt
Date: 10 October 2017 at 15:34
To: Alexander, Minh minhalexander@aol.com

DR

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/uksi/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

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

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

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

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