Professor Stephen Powis
National Medical Director
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Ms Rachel Galloway
HM Assistant Coroner
H.M. Coroner's Office
Manchester City Area
Exchange Floor
The Royal Exchange
Cross Street
Manchester
M2 7EF

10th February 2020

Dear Ms Galloway

Re: Regulation 28 Report to Prevent Future Deaths – Stuart Clarke, 27 June 2019

Thank you for your Regulation 28 Report (hereinafter the 'report') dated 05 November 2019 concerning the death of Mr Stuart Clarke on 27 June 2019. Firstly, I would like to express my deep condolences to Mr Clarke's family.

The report notes that the recent inquest concluded that Mr Clarke's death was a consequence of naturally occurring disease, exacerbated by complications arising out of an aortic valve procedure.

Following the inquest, you raised concerns in the report for the consideration of NHS England regarding a risk that future deaths will occur unless action is taken. In particular you were concerned that there is no national guideline for referral from primary care to secondary care, and/or from secondary care to tertiary care, for patients with known valve disease.

In response please note following the very sad death of Mr Clarke, the cardiac doctors of the Greater Manchester Cardiac Network have reviewed the case and believe that the main issue in Mr Clarke's care was the delay in his specialised treatment. Currently there are no national targets or guidelines on how quickly a patient with a heart condition similar to Mr Clarke's should be diagnosed and then receive the corrective treatment. However if on the first presentation of symptoms Mr Clarke was clinically suitable and eligible for a Transcatheter aortic value implantation (TAVI) procedure, the clinicians believe the length of wait was and is unacceptable.

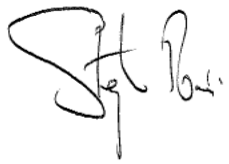
The procedure that Mr Clarke had (TAVI) is only performed at one specialist heart centre in Greater Manchester at Manchester Foundation Trust (MFT). Patients who need this procedure are referred into the service through hospital cardiology departments.

MFT has already started looking at how to improve systems between the two

cardiac centres (Manchester Royal Infirmary and Wythenshawe Hospital) so that patients with this heart condition are able to receive a much quicker service. The Greater Manchester Cardiac Network, which includes cardiac doctors, nurses and other health professionals will now look at how they could support and extend the work being done at MFT to improve this heart care pathway so that people across GM are better identified by General Practitioners (GPs) and then sent to the right heart specialist centre to have the procedure done much quicker than is currently the case.

Thank you for bringing this important patient safety issue to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



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