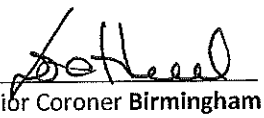
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Heart of England NHS Foundation Trust** **2. NHS England**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 09/03/2016 I commenced an investigation into the death of Terence Henry Stilges. The investigation concluded at the end of the inquest 28th June 2016. The conclusion of the inquest was that the deceased died from a myocardial infarction which was not diagnosed before he was discharged home from hospital on 09/12/15. A troponin blood test and referral to a cardiologist should have been completed which would have resulted in him staying in hospital for further treatment.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was admitted to Birmingham Heartlands Hospital on 06/12/15 having collapsed. He suffered from severe COPD. The cause of his collapse was investigated with a provisional diagnosis of pulmonary embolism. Tests were undertaken including a troponin test (a blood test which is a marker of myocardial infarction and acute pulmonary embolism). He was reviewed on the ward round on 08/12/15 when the troponin result was 520. A further troponin was taken at 10.00 on 08/12/15. This sample was not tested as it was incorrectly labelled so another sample was taken at 16.00. He was reviewed on the morning ward round on 09/12/15 when he said he wanted to go home to attend his sister's funeral. The troponin had again been incorrectly labelled so the result was unavailable. The medical records clearly documented that the plan was for the deceased to go home. The nursing notes recorded his discharge at 11.05. At 17.21 on 10/12/15 the deceased was readmitted to Birmingham Heartlands Hospital with severe shortness of breath and intermittent chest pain. He was diagnosed as suffering from an acute myocardial infarction. He did not satisfy the criteria for urgent intervention. He was treated in hospital until he died following a cardiac arrest on 12/12/15.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) A discharge summary was prepared several days in advance for this patient. This summary did not mention the need for a further troponin result before the patient was discharged home. In addition the medical records wrongly specified that he should be discharged home. Therefore the patient was incorrectly sent home before the second troponin result was available. I heard that there was a practice of writing discharge summaries in advance despite tests results being outstanding. I am concerned this

	could result in other patients being discharged before their tests are complete.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, Heart of England NHS Foundation Trust, have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 August 2016. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the Family of the deceased. I have also sent it to NHS England who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	30/06/2016 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**