REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Birmingham Women and Childrens Hospital NHS Foundation Trust**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 the 11th June 2021, I commenced an investigation into the death of Kellum Paul Thomas aged thirteen years. The investigation concluded at the end of the inquest on the 8th July 2022. The conclusion of the inquest was Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** Kellum collapsed at his home address around 20.00 hours on the 9th June 2021. He had a cardiac arrest from which he could not be resuscitated, and was pronounced deceased at Queens Medical Centre, at 21.37 hours on that day. He had a REVEAL device in situ, to monitor his heart rate and rhythm, which showed that he developed Ventricular Tachycardia (VT), deteriorating into Ventricular Fibrillation (VF) leading to his death. The REVEAL device had been in place from 2016 (when he very likely had a previous cardiac arrest), although the battery in this device had stopped functioning likely in September 2019. The device was not replaced until February 2021. Whilst there had been no previous documented episodes of VT or VF, only clusters of extra ventricular beats, there was a missing period of recording of heart rate and rhythm between Sept 19 and February 2021. There was no clear indication for treatment with an implantable Defibrillator based on his presentation and REVEAL device recordings, although this decision had been considered carefully. There was a working diagnosis of a rhythm disorder of the heart known as Catecholaminergic Polymorphic Ventricular Tachycardia, although this was not proven in life, though now thought likely to be the cause of his death based on the final rhythm change and the normal structure of the heart confirmed at Post Mortem examination. Kellum was seen in March 2021 by his Cardiologist, and was well. The planned increase in Atenolol was not implemented following this appointment, as the letter to the GP to initiate the change did not reach the GP until after Kellum's death. Whilst there were issues of care in this case, I cannot say they have caused or made a significant contribution to his death on a balance of probability, as the fatal rhythm

	change had not been demonstrated previously, and Kellum had had no ongoing symptoms to suggest he was at risk of a fatal arrhythmia.
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. Kellum was without a REVEAL device to monitor his heart rate and rhythm for an 18 month period, despite this being an agreed necessary part of his treatment. The evidence from [redacted], Consultant Paediatric Cardiologist, was that there was no robust system for clearly identifying when a battery within a REVEAL device, came to the end of its life, nor was there a robust system for managing the list of children waiting for a replacement device. Also that the waiting list for a device change was excessively long (over 12 months for urgent cases, and longer for those less urgent). Also that capacity and resources were very stretched as the Specialist Paediatric Cardiology team dealing with these issues, was small, and covering both East and West Midlands. 2. Kellum's outpatient letter from [redacted] to both the GP and to Nottingham University Hospitals NHS Trust (where shared care was provided) was very delayed, with the outpatient appointment completed in March 21, and the letter not reaching its destinations until mid June 21, after Kellums death. This letter contained important information re a change in medication dosage and a request for NUH to arrange a further investigation. Again this issue appeared to be one of team capacity and resources. I am not reassured that necessary actions to address either of these serious issues identified are in place.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you 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 the **29th September 2022**. 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.

	For the avoidance of doubt, I will require a response from the Chief Executive of the Birmingham Women and Childrens NHS Foundation Trust, however understand that there will likely need to be a discussion with, and potentially a joint response from, the NHS Commissioning team.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: 1. Parents of Kellum 2. Nottingham University Hospitals NHS Trust, via the Legal team for the attention of the Clinical Director, Family Health Services- for information only 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	**3rd August 2022** **Dr E A Didcock**