Regulation 28: Prevention of Future Deaths report

Trevor Coy BAILEY (died 09.05.23)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Medical Director** **Northwick Park Hospital** **Watford Road** **Harrow HA1 3UJ**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 18 May 2023, one of my assistant coroners, Edwin Buckett, commenced an investigation into the death of Trevor Bailey aged 63 years. The investigation concluded at the end of the inquest on 18 October. I made a determination at inquest of death by natural causes. Mr Bailey's medical cause of death was: 1a) extensive acute myocardial infarction of the left ventricular wall 1b) severe coronary artery stenosis (stented) 1c) atherosclerosis
4	**CIRCUMSTANCES OF THE DEATH**

	Mr Bailey attended Northwick Park Hospital emergency department on 19 April 20223 with chest pain, two and a half weeks before his fatal myocardial infarction on 7 May 2023. He was investigated and discharged without referral to the rapid access chest pain clinic because his test results proved negative and he seemed stable.
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. I heard evidence at inquest that Mr Bailey was a (very recently ex) smoker with a family history of ischaemic heart disease – his brother had had two cardiac stents placed in 2006 and two in 2012. However, it does not appear that these two pieces of information were elicited by those assessing Mr Bailey in the emergency department of Northwick Park Hospital. I heard evidence that, if they had been, he should have been referred to the rapid access chest pain clinic. Given the sequence of events, it seems unlikely that such a referral would have resulted in definitive treatment before Mr Bailey's fatal myocardial infarction, but it could be a life saving referral for another patient in Mr Bailey's position.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 18 December 2023. 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 following. • [redacted], wife of Trevor Bailey • Care Quality Commission for England • Professor Chris Whitty, Chief Medical Officer for England • [redacted] consultant cardiologist, Royal Free Hospital • [redacted], GP, Church Lane Surgery • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 20.10.23 *ME Hassell*