# **Regulation 28: Prevention of Future Deaths report**

# Trevor Coy BAILEY (died 09.05.23)

# THIS REPORT IS BEING SENT TO:

1. The Senior Partner
Church Lane Surgery
282 Church Lane
Kingsbury
London NW9 8LU

#### 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.

1. I heard evidence at inquest that Mr Bailey had a family history of ischaemic heart disease – his brother had had two cardiac stents placed in 2006 and two in 2012.

However, this information was not on Mr Bailey's medical record, it was not elicited at his 2012 or 2018 health checks and it was not elicited when he consulted his general practitioner, on 19 or 27 April 2023.

The recording of this information is unlikely to have changed the outcome for Mr Bailey, but it was a vital part of the medical history and it might easily for another patient.

2. told me in the witness box that she had identified immediately after Mr Bailey's death in May 2023 that the duty doctor system at Church Lane Surgery does not allow sufficient time to deal with patients appropriately. However, she has not progressed this issue in the five months since.

### 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.

- wife of Trevor Bailey
- Care Quality Commission for England
- Professor Chris Whitty, Chief Medical Officer for England
- consultant cardiologist, Royal Free Hospital
- medical director, Northwick Park Hospital
   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.

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SIGNED BY SENIOR CORONER

20.10.23

ME Hassell