Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1** [redacted]
1	**CORONER** I am Gareth JONES, Assistant Coroner for the coroner area of West Sussex, Brighton and Hove
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 21 March 2023 I commenced an investigation into the death of Noura HARDY aged 73. The investigation concluded at the end of the inquest on 18 June 2024. The conclusion of the inquest was that: Noura Hardy died on the 14th of March 2023 at Royal Sussex County Hospital in Brighton of a cardiac arrest following a septal ablation procedure complicated by perforation of a coronary artery.
4	**CIRCUMSTANCES OF THE DEATH** Ms. Hardy suffered from severe left ventricular hypertrophy. She was admitted to hospital in March 2023 for a septal ablation procedure. Her coronary artery was perforated before the procedure. She subsequently died of a cardiac arrest.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows: In addition to her heart difficulties, Ms. Hardy had taken steroids for a long period of time for temporal arteritis. She was put on a waiting list for her heart treatment in June 2022 but not treated until March 2023, nine months later. The evidence of the Cardiac Surgeon [redacted] who gave evidence at the Inquest was that the long term steroid use significantly weakened her heart muscles such that she suffered a perforation which subsequently led to her death. If she had been treated earlier, the muscles may not have been weakened to such an extent that she died. The local Trust (UHS Foundation Trust)

	assures me that waiting lists for heart treatment are now between 9 and 22 weeks which is reassuring. However I am still concerned about waiting lists for heart treatment being too long and consider this a national problem. Excessive waiting lists for heart treatment can be fatal.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 September 12, 2024. 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 following Interested Persons • [redacted] • **University Hospitals Sussex NHS Foundation Trust** who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 18/07/2024** **Gareth JONES** **Assistant Coroner for** **West Sussex, Brighton and Hove**