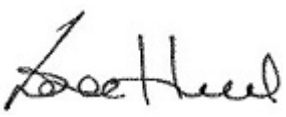
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **University Hospitals Birmingham NHS Foundation Trust**
1	**CORONER** I am Louise Hunt, Senior Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 11 June 2024 I commenced an investigation into the death of Joan Margaret KNIGHT. The investigation concluded at the end of the Inquest . The conclusion of the inquest was; Died from the consequences of a recognised complication following treatment for severe coronary artery stenosis
4	**CIRCUMSTANCES OF THE DEATH** Mrs Knight suffered an acute inferior wall myocardial infarction on 16/05/24 and had treatment by way of angioplasty to her right coronary artery with a stent being fitted. The procedure was complicated as she was found to have significant calcium build up in the coronary artery. It was also noted that the left anterior descending artery had severe narrowing. Initially after the procedure she was pain free; however she began to experience further chest pain on 18/05/24 which was treated with medication. The chest pain recurred on 20/05/24 and a further procedure to insert a stent into the left anterior descending artery was undertaken on 21/05/24. During the procedure access was difficult and significant calcification was noted. During ballooning the coronary artery ruptured and was successfully treated with a stent. Whilst initially stable after the procedure her condition deteriorated, and she presented with an unrecordable blood pressure. A bedside echocardiogram confirmed a collection of blood around the heart and an emergency pericardial aspiration was undertaken and she was taken back to the cardiac catheter lab where a covered stent was fitted to try to treat the bleeding at the site of the previous perforation. The bleeding was difficult to control and arrangements were made to transfer her to the Queen Elizabeth Hospital where a CT scan confirmed bleeding in the abdomen. She was taken to theatre where no site for bleeding was found in the abdomen; however a small perforation in the right ventricle was identified and repaired which was likely caused when the emergency aspiration procedure was undertaken. Sadly, she developed multi organ failure in the post operative period and passed away on 25/05/24. Based on information from the Deceased's treating clinicians, the medical cause of death was determined to be: 1a Multiple organ failure 1b intrabdominal bleeding from chest compressions and ventricular bleeding secondary to emergency pericardial aspiration (operated) 1c cardiac tamponade 1d treatment for severe stenosis of the left anterior descending coronary artery leading to perforation and bleeding

	II Myocardial infarction (treated)
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. The mortality review that was undertaken in this case was completed incorrectly and contained contradictory terms about whether the death was avoidable. This raises a concern that mortality reviews are not being conducted correctly and that there could be inadequate learning from cases raising a risk of future deaths.
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 17 December 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: The family of Mrs Knight. I have also sent it to the Medical Examiner, ICS, NHS England, CQC. 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	**22 October 2024** Signature:  **Louise Hunt** **Senior Coroner for Birmingham and Solihull**