## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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| | **THIS REPORT IS BEING SENT TO:**<br><br>**South Tees Hospitals NHS Foundation Trust** |
| **1** | **CORONER**<br><br>I am Paul Appleton, HM Assistant Coroner for the Coroner Area of Teesside & Hartlepool |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 09 August 2023, I commenced an investigation into the death of John COGDON, aged 62.<br><br>The investigation and the inquest have not yet concluded. An initial inquest hearing occurred on 8 November 2024 and went part-heard, with a further hearing to be listed. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>On 26 June 2023, Mr Cogdon had coronary artery bypass graft surgery at the James Cook University Hospital, Middlesbrough. He deteriorated following that surgery and died on 4 August 2023.<br><br>The proposed medical cause of death has been offered as:<br><br>1a) Congestive Cardiac Failure;<br>1b) Coronary Artery Bypass Graft Surgery for Coronary Artery Atheroma on a background of Peripheral Vascular Disease. |
| **5** | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>1. At hearing on 8 November 2024, I heard evidence that different Wards/Departments within the James Cook University Hospital, Middlesbrough utilise different record-keeping and prescribing systems (including paper based and electronic based systems). I am concerned that the Trust's record keeping and prescribing systems are fragmented and lack integration. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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. |

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| **7** | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 10 January 2025. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>1. The Deceased's family.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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.<br><br>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: 15/11/2024**<br><br>**Paul APPLETON**<br>**Assistant Coroner for**<br>**Teesside and Hartlepool Coroner's Service** |