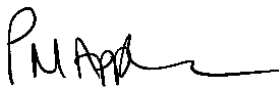




Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	<p>THIS REPORT IS BEING SENT TO:</p> <p>South Tees Hospitals NHS Foundation Trust</p>
1	<p>CORONER</p> <p>I am Paul Appleton, HM Assistant Coroner for the Coroner Area of Teesside & Hartlepool</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION</p> <p>On 09 August 2023, I commenced an investigation into the death of John COGDON, aged 62.</p> <p>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.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>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.</p> <p>The proposed medical cause of death has been offered as:</p> <p>1a) Congestive Cardiac Failure; 1b) Coronary Artery Bypass Graft Surgery for Coronary Artery Atheroma on a background of Peripheral Vascular Disease.</p>
5	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)</p> <ol style="list-style-type: none">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	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>



7	YOUR RESPONSE 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. 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: 1. The Deceased's family. 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	Dated: 15/11/2024  Paul APPLETON Assistant Coroner for Teesside and Hartlepool Coroner's Service