University Hospitals of North Midlands NHS Trust

Trust Ref: [redacted]

Executive Suite
Springfield Building
Royal Stoke
Newcastle Road
Stoke on Trent
ST4 6QG

11 February 2025

STRICTLY PRIVATE & CONFIDENTIAL
Mr Duncan Ritchie
Assistant Coroner
Stoke on Trent and North Staffordshire

Sent via email: [redacted]

[redacted]

Dear Mr Ritchie

Anne Patricia LEAKE

Further to your letter dated 16 December 2024, I am pleased to provide a response under paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013, addressing your concerns surrounding the death of Anne Patricia Leake.

Recorded Circumstances of the Death
Mrs Leake suffered arrhythmia and cardiac arrest on 17 April 2024. She was admitted to the Royal Stoke University Hospital and a multi-disciplinary team (MDT) of doctors decided that she was to have heart valve surgery and have an Implantable Cardioverter Defibrillator (ICD) fitted before she was released from hospital. The purpose of the ICD was to prevent Mrs Leake from suffering future cardiac arrhythmia and cardiac arrest.

A few days later, Mrs Leake underwent heart valve surgery as planned, but she was then mistakenly released from hospital without having fitted the ICD which she needed.

Three days after she was released from hospital Mrs Leake suffered a cardiac arrhythmia of the type which an ICD is designed to address, and she died as a result.

I found that the failure to fit the ICD was causative of Mrs Leake's death and it amounted to neglect.

The decision of the MDT to fit the ICD was overlooked by the doctors who released Mrs Leake from hospital because the note of the MDT meeting which made this decision was not recorded on the medical notes which they were working from.

Concerns
During the course of the inquest, you felt that evidence revealed matters giving rise for concern. In your opinion, matters for concern are as follows:

1. Mrs Leake received treatment from three hospital teams: cardiology, cardiothoracic surgery and coronary intensive care. Each team uses their own ward-based medical notes which are not accessible by the other teams. Whilst each team has access to the iPortal system on which Mrs Leake's MDT decision was stored, it was apparent that this was not accessed and acted upon. As a result, the MDT decision regarding Mrs Leake's ICD was overlooked.

2. Plans to introduce electronic patient records to which all medical teams have access are still at an early stage and no date has been identified for moving over to a single electronic notes system.

3. The steps which the Trust has taken as a result of Mrs Leake's death to address the risk of MDT decisions being missed in the future still rely upon the manual transcription of decisions from one set of medical notes to another, with the continuing potential for human error and important decisions about treatment being overlooked.

You reported this matter under Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

In your opinion, action should be taken to prevent future deaths.

Action Taken
The University Hospitals of North Midlands NHS Trust has taken the issues highlighted during the inquest seriously and indeed, I am grateful that you have raised your concerns to which a response is provided below.

Response to all Concerns Raised
In considering the points of concern set out above, the Trust accepts that a Trust wide electronic patient record (EPR) to provide a single source of patient information is likely to have ensured that the MDT decision regarding the need for Mrs Leake's ICD was known to all the teams providing her care. Such a system would ideally, in addition, include alerts to ensure that she was discharged safely.

As an immediate action, the development of a new alert within iportal will be implemented – this will be populated by the multidisciplinary team to inform clinicians that an ICD is required prior to discharge. The team are going to introduce teaching into the resident doctor induction to ensure this is checked prior to discharge.

However, at the current time, the Trust currently uses many digital systems, in addition to being heavily reliant upon paper records. The clinical systems used, are bespoke to the needs of specific clinical teams and their patients, but unfortunately, cannot always share information with, or be accessed by, other teams and specialties.

For an organisation the size of UHNM, with a wide range of specialist services, a single EPR cannot be achieved by consolidating the current systems, which have struggled under growing requirements. As such, it is acknowledged that there is a continued risk of transcription and/or human error in relation to sharing of important clinical information until these issues have been addressed. This matter remains as a significant risk on the corporate risk register and is frequently assessed.

Whist the Trust aspires to acquire a new, highly sophisticated, purpose-built single EPR system, this will necessitate securing significant capital investment, development and time to ensure safe deployment. To support this ambition, the trust is currently engaged in setting out a new digital vision and strategy, which includes the goal for a new EPR across the whole Integrated Care System (ICS).

The UHNM digital team together with the ICS, are drafting a business case to apply for NHS funding for an EPR that will meet our growing needs and provide the functionality and interoperability required to prevent the events that contributed to Mrs Leake's death.

It is hoped that the issue of a Regulation 28 from HM Coroner will further highlight the urgency of a new system and the financial support it requires. Once funding is secured, the safe development and deployment of a system should take a minimum of 18-24 months. Until this time, we are limited by the capability of our current information and technology infrastructure.

Ongoing work to optimise the digital systems aligned to the highest clinical risks will continue within UHNM. This will be undertaken alongside continued work to understand the patient safety risks across all of our current digital systems in order to develop mitigating actions. As you are aware, those specific to Mrs Leake's case have already been outlined in an after action review (AAR) following an investigation of the case.

We do hope that the above information provides assurance that the Trust has taken the concerns raised at the inquest seriously and that both you and Mrs Leake's family are content with the response that has been provided.

Should you wish to discuss any aspect of this report further, please do not hesitate to contact me directly.

Yours sincerely

[redacted]

CHIEF EXECUTIVE