REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] – Chairman of University Hospitals of North Midlands NHS Trust**
1	**CORONER** I am Duncan Ritchie, assistant coroner for the coroner area of Staffordshire & Stoke-on-Trent.
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 13th June 2024 I commenced an investigation into the death of Anne Patricia Leake, aged 67. The investigation concluded at the end of the inquest on 9th December 2024. The medical cause of death was: 1a Hypoxic brain injury 1b Cardiac arrest 1c Ventricular arrhythmia The narrative conclusion was: Natural causes contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Leake suffered arrhythmia and cardiac arrest on 17th 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.

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 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. – (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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that your organisation has 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 **10th February 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 Person: • [redacted] (Mrs Leake's husband) 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. She may send a copy of this report to any person who she 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	**16th December 2024** **D J Ritchie**