Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 NHS England** **2 Secretary of State for Health**
1	**CORONER** I am Elizabeth GRAY, Area Coroner for the coroner area of Cambridgeshire and Peterborough
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 21 April 2021 I commenced an investigation into the death of Patricia CURTIS aged 80. The investigation concluded at the end of the inquest on 21 November 2024. The conclusion of the inquest was that: Patricia Curtis died as a result of a known, but extremely rare complication of necessary post operative treatment
4	**CIRCUMSTANCES OF THE DEATH** Mrs Curtis underwent mitral valve repair, tricuspid valve repair, coronary artery by pass grafting x 3 and atrial appendage exclusion on 17 March 2021 at Royal Papworth Hospital. Her post operative recovery was lengthy and she was repatriated to Bedford Hospital on 1 April 2021. On 2 April 2023 following arrival at Bedford Hospital Mrs Curtis deteriorated rapidly in the early hours of the morning. Post mortem examination determined that her cause of death was a haemothorax which on the balance of probability had started to develop gradually following a removal of her chest drain at Royal Papworth Hospital before transfer to Bedford Hospital. Clinical signs of the haemothorax were first identifiable at 1am on 2 April 2021 when Mrs Curtis' medical assessment detected decreased air entry on her left side following prior examination results which showed equal air entry. Haemothorax did not form part of the differential diagnosis for Mrs Curtis at 1am on 2 April 2021 and she continued to be treated for her presenting complaints of fast atrial fibrillation, low blood pressure and severe heart failure and possible myocardial ischaemia due to low blood pressure. A chest X-ray was not considered to be necessary as Mrs Curtis was not presenting with a primary lung cause and her respiratory system did not seem particularly affected at that time. It is not possible to say whether a chest X-ray would have identified a haemothorax. It was recognised by the treating clinicians that Mrs Curtis was very unwell and it was determined that Mrs Curtis would be unlikely to survive Intensive Care Unit care.
5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows:

	Hospital Discharge notes are not uniform across Hospital Trusts. This carries the risk of essential patient information not being available to treating clinicians when a patient is received into a new clinical setting, leading to potential delay in providing life saving care and treatment.
6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 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 **Family of Patricia Curtis** **Bedford Hospital** **Royal Papworth Hospital** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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 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: 04/12/2024** Elizabeth A. C Gray **Elizabeth GRAY** **Area Coroner for** **Cambridgeshire and Peterborough**