Quarry Bank Medical Centre
High Street
Quarry Bank
Brierley Hill
West Midlands
DY5 2AE
4 April 2026

Mr Zafar Siddique
Senior Coroner
Black Country Area

Re: Regulation 28 Report to Prevent Future Deaths – Mr Stephen Martin Rhodes (Deceased)

Dear Mr Siddique,

We write in response to the Regulation 28 Report to Prevent Future Deaths sent to Quarry Bank Medical Centre ("the Practice"), dated 6 February 2026. We are pleased to confirm that this response is provided within the 56-day period required, by 6 April 2026.

We have taken the circumstances surrounding the death of Mr Rhodes extremely seriously. A formal written response has been sent to Mrs Rhodes offering condolences, setting out the circumstances as understood by the Practice, and detailing the system-level changes implemented following review. The Practice has also offered to meet with Mrs Rhodes in person to discuss the matter further should she wish to do so. The Practice has engaged openly and transparently throughout the coroner's investigation and will continue to do so.

By way of context, laboratory blood test results are transmitted directly from ICE, the laboratory reporting system, into EMIS Web, the Practice's clinical system. EMIS Web has an inbuilt results management filter function. When laboratory results are received, the ICE system assigns an abnormal alert flag to any result that falls outside the defined reference range. Within EMIS Web, each GP manually applies the results management filter by clicking within the system. This filter segregates incoming results into two distinct categories based on the presence or absence of a laboratory abnormal alert flag: those carrying an alert, which require clinical review and action, and those without an alert, which are filed as normal results. The purpose of applying this filter is twofold: to file normal results efficiently, and to identify and take prompt clinical action on abnormal results. This ensures that results requiring attention are not overlooked within the volume of daily pathology reports and that each GP can direct focused clinical review to those results that carry a laboratory abnormal alert. Each GP is expected to review and action their results within 24 hours of receipt.

In respect of the late Mr Rhodes, blood tests including NT-proBNP were requested on 13 September 2024 following presentation with progressive shortness of breath. A chest X-ray was also requested. The blood test results were received on 17 September 2024. The requesting clinician did not review and file the results at the time they became available. The results were subsequently reviewed and filed by a different clinician. As the NT-proBNP result did not carry a laboratory alert flag at that time, it was not identified as requiring action during the manual filtering process and entered the normal results pathway, where it was processed and filed without the laboratory's recommendation for urgent specialist referral being actioned.

We wish to address the chest X-ray result separately. The X-ray report indicated findings in keeping with suspected COPD, consistent with the clinical indication on the request form. This result was reviewed, acted upon, and followed up: spirometry was requested to confirm the diagnosis and reception staff were tasked with contacting Mr Rhodes to inform him of the results and arrange the necessary referral. The pathway failure in this case was therefore specific to the NT-proBNP result not carrying a laboratory alert flag, rather than reflecting a general failure of results management across the Practice.

Please find enclosed a copy of the Significant Event Analysis (SEA) minutes for your records.

Significant Event Analysis

A formal Significant Event Analysis was initiated on 30 April 2025, led by the Practice Manager, [redacted] The SEA was reviewed and updated on 18 February 2026 following the conclusion of the coroner's inquest. The review involved clinical and administrative input and examined the systems and processes surrounding the ordering, receipt, filing, and actioning of the late Mr Rhodes' blood test results. The primary cause was identified as failure to appropriately scrutinise and act upon a significantly abnormal NT-proBNP result, with contributory factors including the absence of a laboratory alert flag, the high daily volume of pathology reports, and the absence at that time of a structured escalation protocol for high-risk cardiac biomarkers. All agreed actions were completed by 18 February 2026. The SEA records the likelihood of reoccurrence as rare.

Duty of Candour

The Practice confirms that its Duty of Candour obligations under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 have been discharged. This was completed on 18 February 2026, as recorded within the enclosed SEA. The Practice wishes to highlight that it was the Practice itself that first identified the issue following the death of the late Mr Rhodes, and proactively communicated with Mrs Rhodes following the conclusion of the coroner's inquest on 29 January 2026. The written response sent to Mrs Rhodes acknowledges the findings of the inquest, offers condolences, and sets out the changes implemented by the Practice. An offer to meet in person has also been extended.

Actions Taken

The following changes have been implemented, all with effect from 18 February 2026 unless otherwise stated:

1. Laboratory Reporting (actioned 14 March 2025): On 14 March 2025, the Practice wrote to Russells Hall Hospital laboratory to notify them that their reports were not including an alert on raised NT-proBNP results. The laboratory conducted a review and their reports now include an alert when NT-proBNP results are raised. As these results now carry a laboratory red flag indicator, they are correctly identified during the Practice's manual filtering process and routed into the action-required category for clinical review. The laboratory has also updated its report format so that all abnormal results are flagged on the first page of each report. This change will benefit all practices receiving reports from this laboratory and materially reduces the risk of a similar event occurring across the wider system.
2. MY Bot AI Triage System (implemented 18 February 2026): The Practice introduced the MY bot AI triage system on 18 February 2026 following a careful, phased assessment to ensure clinical accuracy and safety prior to full adoption. MY bot works by applying an intelligent filter to incoming blood test results, segregating them into two categories: results that require clinical action and results that do not require action. This enables each GP to focus their review directly on results requiring

attention, rather than manually scanning the full volume of daily pathology reports – which, as noted at inquest, can run to several hundred per day. The system underwent supervised validation to ensure that no clinically significant result was misclassified before it was relied upon as part of the Practice's results management pathway. This directly addresses the concern raised at inquest regarding the risk of significant findings being overlooked within a high-volume routine workflow. MY bot additionally flags to the duty doctor, on the day of receipt, any urgent results electronically flagged as abnormal by the laboratory – including NT-proBNP, Gamma GT, CRP, and PSA – which must be actioned that day or tasked to the requesting GP. We note that, as the laboratory had not assigned an alert to NT-proBNP at the time of the late Mr Rhodes' blood tests, MY bot would not have flagged his result at that point. However, following the laboratory's reporting update (paragraph 1 above), any future raised NT-proBNP result will be electronically flagged and automatically segregated into the action-required category, bringing it to the duty doctor's attention on the day of receipt. The laboratory alert change and MY bot together provide a combined safety net that did not exist at the time of the late Mr Rhodes' presentation.

3. Revised Results Management SOP (18 February 2026): The Results Management Policy has been formally revised and reissued. The updated SOP explicitly mandates that the requesting clinician retains responsibility for the review, interpretation, actioning, and filing of all investigation results within 24 hours of availability. An automated alert is generated where results remain unfiled beyond this defined timeframe, with escalation to the clinical lead where defined backlog thresholds are exceeded.
4. Mandatory Same-Day Protocol for Raised NT-proBNP (18 February 2026): A mandatory same-day clinical review and documented action protocol has been introduced for all NT-proBNP values exceeding 400 – the threshold above which results are considered abnormal. The Practice has deliberately adopted this more conservative threshold rather than the NICE urgent referral threshold of >2000, to ensure that any raised NT-proBNP result, however early in its trajectory, receives prompt clinical attention on the day of receipt without exception.
5. High-Risk Biomarker Escalation Framework and Abnormal Alert System (18 February 2026): The "Abnormal Alert" system has been introduced within EMIS Web as an additional safety check. A defined list of critical biomarkers – including NT-proBNP, markedly abnormal potassium, CRP, and PSA – has been agreed, with results exceeding defined thresholds flagged for enhanced scrutiny. No result carrying a laboratory recommendation for onward referral may now be filed without documented clinician acknowledgement. Where a referral recommendation is not followed, a documented clinical reason must be recorded.
6. Cross-Filing Safeguard and Secondary Review (18 February 2026): Where results are reviewed and filed by a clinician other than the requesting GP, that clinician must send the requesting GP a task to review the results upon their return, ensuring a secondary review by the clinician with full knowledge of the clinical context. A secondary review safeguard has additionally been introduced for specified critical cardiac biomarkers to provide additional oversight where results exceed urgent referral criteria.
7. Clinical Documentation and Safety Netting (18 February 2026): The Practice has reiterated to all clinical staff the importance of recording the clinical reason for each investigation request in the patient's record, so that any covering clinician reviewing results does so with full awareness of the clinical context. Safety netting now routinely includes advice to patients to contact the Practice to check their results.
8. Clinical Audit Programme (18 February 2026): The Practice has developed a programme of practice-level clinical audits targeting results of high clinical significance, designed to provide ongoing assurance that abnormal results are identified, actioned, and that time-bound referral recommendations are completed within the specified timeframe. The audit programme includes NT-proBNP and BNP,

PSA, and other clinically significant markers, to be expanded through ongoing clinical governance review. Audits are conducted on a fortnightly basis with outcomes reported to the monthly clinical governance meeting, at which results management is now a standing agenda item. A quarterly audit of NT-proBNP results and associated referral pathways will be conducted for a 12-month period to provide sustained assurance of compliance. The initial audit has confirmed that no other raised results have been missed.

9. Staff Training and Wider Sharing (18 February 2026): Refresher training has been provided to all clinical and administrative staff involved in the results management pathway. The findings of the SEA, the inquest, and the lessons learned have been shared with the wider practice team in a whole-practice learning session. The Practice is actively planning to share the audit framework and learning with all practices within the Dudley Primary Care Network. We note that the laboratory's updated reporting format, which now flags all abnormal results prominently, will itself materially reduce the risk of a similar event across all practices using Russells Hall Hospital laboratory, further reducing the likelihood of recurrence beyond the Practice's own boundaries.

Personal Professional Reflection

The clinician involved has reflected fully and openly on this case. The matter was brought to the GP's responsible appraiser in February 2026 and has been formally documented within the annual appraisal and revalidation portfolio as a significant event. In addition, the clinician has enrolled on the Red Whale 'Managing Blood Results' course to support structured learning and reinforce safe practice in this area. The Practice considers this personal engagement with learning to be an important component of the overall response to this incident.

Notification to Relevant Authorities

The Practice confirms that the incident has been reported to and is known to Black Country Integrated Care Board. Upon identifying the issue, the Practice proactively notified Dudley Place, the ICB primary care team, and specifically raised the absence of an abnormal alert on NT-proBNP results within laboratory reports. The Practice requested that action be taken to ensure the laboratory implemented the alert, in order to protect not only patients of this Practice but patients across all practices receiving reports from Russells Hall Hospital laboratory. The Practice has maintained open communication with the ICB throughout this process and is pleased to confirm that the laboratory has since acted upon this. Russells Hall Hospital laboratory now reports NT-proBNP results with a clear abnormal alert flag, meaning any raised NT-proBNP result will be automatically identified during the results management filtering process and routed for clinical action. This change prevents any future instance of a raised NT-proBNP result being missed in the manner that occurred in this case.

Response to NHS England's Involvement

The Practice notes that a copy of the Regulation 28 Report has been sent to NHS England and fully supports the Coroner's suggestion that NHS England may wish to review national guidance for laboratories regarding the flagging of abnormal results. The Practice's direct experience in this case demonstrates that a laboratory's failure to flag an abnormal result at source can silently circumvent even well-designed electronic filtering systems at practice level. National standardisation of laboratory alert protocols would represent a meaningful and systemic patient safety improvement. The Practice would welcome any such guidance.

Ongoing Monitoring

Ongoing compliance with the revised protocols will be monitored jointly by the Practice Manager and GP Partner through monthly clinical governance meetings, at which results management is a standing agenda item. The effectiveness of all changes will be formally reviewed at three and six months from the date of this response, with outcomes documented. Any further corrective action identified will be implemented promptly.

We hope this response, together with the enclosed SEA, demonstrates the comprehensiveness and seriousness with which Quarry Bank Medical Centre has responded to this incident. The Practice has implemented substantive, system-level changes that address each of the contributory factors identified, and is committed to ensuring that the circumstances that led to Mr Rhodes' death are not repeated. We remain committed to the highest standards of patient safety.

Yours sincerely,

[redacted] [redacted]

Practice Manager GP Partner

Quarry Bank Medical Centre

Enc: Significant Event Analysis – SEA 3145 (Missed Abnormal Pathology Result), Quarry Bank Medical Centre