REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **NHS England (Reg 28 Reports) -email address** [redacted] 2. **Practice Manager, Quarry Bank Medical Centre**
1	**CORONER** I am Mr Zafar Siddique, Senior Coroner for the Black Country.
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 https://www.legislation.gov.uk/uksi/2013/1629/part/7
3	**INVESTIGATION and INQUEST** On 23 July 2025, I commenced an investigation into the death of Mr Stephen Martin Rhodes, born on the 30 January 1959, who died on the 11 March 2025. The investigation concluded at the end of the inquest on 29 January 2026. The inquest was heard before me and the conclusion at inquest was a narrative conclusion: Natural causes contributed to by neglect. The medical cause of death was recorded as: 1a Hypertensive Heart Disease due to 1b Aortic stenosis
4	1. Mr Rhodes was a 66-year gentleman who was experiencing shortness of breath and was until recently a smoker. He saw his GP on 13 September 2024 after he presented with symptoms of progressive shortness of breath. The GP requested routine blood tests, including NT-Brain Natriuretic Peptide (NTproBNP is a marker of increased left atrial pressure and screen for heart failure). 2. His reading was significantly raised at 3473 (normal expected for this age group is less than 400). 3. The advice from the laboratory was to refer for specialist assessment and transthoracic echocardiography within two weeks. A chest x-ray was also ordered. 4. The blood test results were then filed in the mistaken belief there was no abnormal result findings. 5. Mr Rhodes continued to work as a delivery driver and whilst undertaking a delivery at Oaklands College in Hertfordshire, he collapsed on the 11 March 2025 and sadly passed away after developing a cardiac arrest. 6. There was a missed opportunity to make a cardiological referral which if it had been made in the suggested two-week period, further tests and treatment could

	have been initiated. It is likely he would have possibly survived with earlier intervention with a diagnosis of hypertensive heart and aortic stenosis. 7. Aortic stenosis once symptomatic with heart failure has a mortality rate of 50% in two years. This contrasts with a surgical risk of 1-2% for aortic valve replacement which could have been offered to him.
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. During the course of the inquest, I heard evidence from health professionals including the General Practitioner and a Consultant Cardiologist. 2. My concern is that the blood test results from the laboratory were not adequately scrutinised by the GP. The blood test results reported on the 17 September 2024 showed normal renal function, normal liver function and bone metabolism. However, the NT-Brain Natriuretic Peptide results which are a marker of increased left atrial pressure and screen for heart failure was markedly raised at 3473 (normal expected for this age group < 400). This was reported to the practice and noted in the practice record with the advice from the laboratory to *"refer for specialist assessment and transthoracic echocardiography within 2 weeks*". 3. The GP giving evidence, described that the Practice could have up to several hundred reports a day. They could not adequately explain how the error occurred. However, one suggestion was that the abnormal results were not found on the front page of the report or highlighted in red. 4. I also heard, evidence that since this incident the laboratory involved has now updated their reporting to ensure that anormal results are flagged on the first page of the report. 5. Given the concerns identified, the GP surgery may wish to review their current processes and at a national level, NHS England may wish to review any guidance for laboratories flagging up abnormal results.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 6 April 2026. 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. 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 other 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. 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.
9	**Mr Zafar Siddique** **Senior Coroner** **Black Country Area** **6 February 2026**