Prevention of Future Deaths Report

Costas CHRYSOSTOMOU (date of death: 14 December 2024)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **Chief Executive Officer** **NHS North Central London Integrated Care Board** **2nd Floor** **Laycock PDC** **Laycock Street** **London** **N1 1TH**
1	**CORONER** I am Ian Potter, assistant coroner for the coroner area of Inner North London.
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/ukpga/2009/25/schedule/5 https://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 18 December 2024, an investigation was commenced into the death of Mr Chrysostomou, aged 87 at the time of his death. The investigation concluded at the end of an inquest heard by me on 24 April 2025 (in St Pancras Coroner's Court) and 23 October 2025 (in Poplar Coroner's Court). The inquest concluded with a short narrative conclusion of "Rare but known complication of a necessary medical treatment (pacemaker)." The medical cause of death was: 1a acute renal failure 1b congestive cardiac failure 1c pacemaker mediated cardiomyopathy II mixed aortic valve disease
4	**CIRCUMSTANCES OF DEATH**

	Costas Chrysostomou was diagnosed with 2:1 AV block and required a dual chamber pacemaker to be implanted to treat this. The implantation took place on 7 October 2024. Mr Chrysostomou attended ED twice (15 and 17 November) and saw a consultant cardiologist privately (26 November) and, while other known cardiac issues were followed up, there was no suggestion that he was in cardiac failure or required an emergency hospital admission on any of these occasions. On 6 December 2024, Mr Chrysostomou was admitted to the Royal Free Hospital and found to have cardiac failure and acute cardio renal syndrome as a consequence. Despite attempts at treatment, Mr Chrysostomou's condition deteriorated and he died in the hospital on 14 December 2024. The heart failure and acute renal failure were a consequence of cardiomyopathy caused by the pacemaker, which is a rare but known complication.
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: Based on the specific circumstances of this case, the evidence was such that the concerns raised in this report, were not likely to have made a difference in the outcome for Mr Chrysostomou. However, I consider that the evidence heard in the course of the inquest would, in different circumstance, result in the risk of future deaths. 1) Use of the term 'urgent' and understanding by third-party providers of the specific Pathways available Following implantation of the pacemaker, Mr Chrysostomou's GP was charged with arranging a follow-up outpatient cardiology appointment and arranging for an echocardiogram (Echo). Both actions were undertaken by the GP. A referral to the cardiology team at the Royal Free Hospital was made under what I was told was a 'generic' cardiology pathway as there was no expectation, at that time, for a more specific pathway to be used. The Echo was undertaken by a third-party (private) provider, contracted to provide services to the NHS. The Echo report was headed in large bold writing: 'Suggest Urgent Cardiac Referral'. The bottom of the Echo report repeats that recommendation next to the heading 'Onward Recommendations'. The evidence I heard indicated that there are numerous potential cardiac/cardiology pathways available. The concern regarding the use of the term 'urgent' is that I heard evidence that this is open to interpretation; for example, there is in some Pathways an 'Urgent 6 weeks' type of referral and also an 'Urgent (<2 weeks)' type of referral. It is possible that the third-party provider(s) may not be aware of the

	differences and/or not sufficiently aware of the NHS ICB Pathways available, which is leading to confusion. 2) <u>Understanding of Pathways</u> a. I heard evidence from cardiology consultants and a GP. It was clear that understanding of the operation of the Pathways differs considerably. One example was that some GPs consider that by custom and practice, if following a routine cardiology referral new clinical information comes to light requiring a patient's referral to expedited or made 'urgent', this can be done by emailing the hospital team concerned and adding the information. However, the view of the hospital consultants is that this is not the case and that if an expedited or urgent referral becomes necessary then the referral process requires re-starting as a new and entirely separate referral. In my opinion, this confusion has the potential to create significant risk. b. I also heard evidence more generally that with more complex specialisms/cases GPs could be assisted with overarching guidance that helps direct them to the most appropriate Pathway. At present, I was told, that the system relies on the GP being confident as to which Pathway is appropriate, which is understandably not always the case.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 5 January 2026. I, the coroner, may extend the period. Your response must contain details of actions taken or proposed to be taken, setting out the timescale 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 the following: • Mr Chrysostomou's family; • Mr Chrysostomou's GP practice; and • The Royal Free Hospital, for information. 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 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	**Ian Potter** **HM Assistant Coroner, Inner North London** **10 November 2025**