Courts and Tribunals Judiciary

RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

When a coroner sends a prevention of future deaths (PFD) report to a person or organisation, they must respond within 56 days. Recipients of a PFD report can apply to the coroner for an extension. A response to a PFD report must detail the action taken or to be taken, whether in response to the report or otherwise, or it must explain why no action is proposed.

The purpose of the response template below is to promote clarity, ensure that responses address the coroner's concerns directly and transparently, and support consistency and good practice across organisations and sectors. It does not restrict how a person or organisation formulates their response; recipients remain responsible for determining what action is appropriate and for ensuring that their response accurately reflects the steps taken or planned.

In accordance with the Chief Coroner's PFD Publication Policy (2026) representations regarding publication of a response should be sent to the coroner. These representations should be made at the same time as the response is provided. The coroner will pass any representations received to the Chief Coroner for a decision

	RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS **REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013** (Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026)) THIS RESPONSE IS BEING SENT TO: HM Assistant Coroner Simon Brenchley for Birmingham and Solihull in response to a 'REPORT TO PREVENT FUTURE DEATH REGULATION 28' following an inquest into the death of Stephanie Link that concluded on 16 April 2026.
1	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, University Hospitals Birmingham NHS Foundation Trust provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths
2	**DATE OF RESPONSE** 17 June 2026

3	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report as follows: 1. During the course of the inquest I heard that as a result of the Patient Safety Incident Investigation ("PSII") into Stephanie's death which concluded in May 2025 a safety action was recommended and accepted by the Trust which was aimed at promoting a clear Multidisciplinary Team approach and care pathway for patients with acute pancreatitis. The target date for implementation of this action was the 30th August 2025. 2. The agreed safety action was, in summary, that a meeting was to be conducted between all UHB hospital sites to discuss and confirm a pathway for patients with complex pancreatitis and to include agreement on (i) the threshold for referring patients between sites (e.g. from Good Hope Hospital to Heartlands Hospital or Queen Elizabeth Hospital which is the regional hepatobiliary specialist centre) including timescales (ii) confirmation on how referrals, treatment pathways and outcomes (including MDT outcomes) are documented on each site and processes for ensuring these are visible between sites and (iii) the processes for shared care between hospital sites and services. 3. However, I heard evidence from one of the Trust's clinical delivery group medical directors that, as at the date of the inquest, whilst meetings had taken place between the specialisms at the different hospital sites regarding the proposed care pathway/MDT arrangements and a draft document setting these out had been discussed, this is still to be finalised and shared with all relevant staff. 4. In this case, I was satisfied that the absence of an effective MDT approach to the management of Stephanie's condition had a more than minimal contribution to her death. I am therefore concerned that there remains a risk of future deaths until such time as there is an agreed, documented care pathway for patients with complex acute pancreatitis that is accessible to and understood by clinicians across the different UHB hospital sites.

4	**DETAILS OF ACTION TAKEN**, how has the concern been addressed. (If no action is proposed please explain why here) Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. A Patient Safety Incident Investigation ("PSII") had been undertaken into Stephanie's death which concluded in May 2025 and included a safety action to promote a clear multidisciplinary approach and care pathway for patients presenting with acute pancreatitis. The target implementation date for the action was 30 August 2025. Whilst the action was not fully completed at the time of the Inquest, a number of steps had been taken, which included discussions between clinical teams, preparation of a draft standard operating procedure with ongoing discussions required to finalist and implement the SOP. Following conclusion of the Inquest cross site teams have developed a multidisciplinary team (MDT) for complex patients in this category. This has been formalised into a SOP which has been shared. The SOP sets out a clear process that all patients with suspected or confirmed necrotising pancreatitis within the Trust should be referred to the appropriate specialist team as follows: • QEHB: referral to the HPB Surgery on-call team • BHH: referral to the BHH Upper GI Surgery team • GHH: referral to the GHH surgical team Patients are currently referred to these teams using referrals via the Electronic Patient Record (PICS or NORSE) or via email. A weekly Pancreatitis MDT has also been established and will discuss the following patients to ensure continuity of care: • patients meeting the operational definition of necrotising pancreatitis where intervention is being considered • suspected or confirmed infected pancreatic necrosis • collections being considered for drainage or necrosectomy • persistent clinical deterioration or ongoing organ failure in the context of necrotising pancreatitis Two patients have already been discussed via the new pathway. Patients with necrotising pancreatitis complicated by symptomatic, infected or persistent collections where intervention is being considered should routinely be listed for MDT discussion. However, if there is clinical concern or if management plans are unclear, cases can be referred for discussion and advice.

	The SOP document is available to all staff on our electronic clinical guidelines site and it has also been cascaded to all Clinical Service Leads, CDG Medical Directors and Hospital Medical Directors via email. It is also proposed that an audit will be undertaken annually to ensure the pathway remains suitable. We are satisfied that the action that remained outstanding at the time of the Inquest is now complete and that an appropriate audit is in place.
5	**DETAILS OF FURTHER ACTION PROPOSED** Please *note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* This will be audited annually.

6	**SIGNATURE**