	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **University Hospitals Birmingham NHS Foundation Trust**
1	**CORONER** I am Mr Simon Brenchley, HM Assistant Coroner for Birmingham and Solihull
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 20 November 2025 I commenced an investigation into the death of Stephanie Anne Barkley Link. The investigation concluded at the end of the inquest which took place on 16th April 2026. The conclusion of the inquest was; Natural causes, contributed to by the absence of an effective multi-disciplinary approach to her management, missed opportunities to transfer her to more specialist care and the continued administration of paracetamol despite deteriorating liver biochemistry.
4	**CIRCUMSTANCES OF THE DEATH** **On 15th April 2024 Stephanie attended Good Hope Hospital emergency department with severe abdominal pain and vomiting and was admitted to a general surgical ward having been diagnosed with acute pancreatis. She was commenced on standard antibiotic therapy together with analgesia (paracetamol) for pain relief but by 24th April a CT scan revealed that she had developed a large peripancreatic cyst which was likely to require drainage via a cystogastrostomy procedure. She was unable to tolerate food and drink owing to compression on her stomach by the cyst so feeding via a naso-jejunal tube was commenced on 29th April but this had to be subsequently paused or was refused by Stephanie on a number of occasions due to pain and a number of instances of vomiting.** **By 13th May, her weight had dropped by 12% since admission owing to a lack of nutrition. She was moved to parenteral feeding but her nutrition continued to be compromised. Her cystogastrostomy procedure had to initially be postponed on a number of occasions due to organizational issues, problems with cannulating her as well as her INR levels being too high for this to take place and the procedure finally took place on 11th June 2024 at Heartlands Hospital to which she was transferred for the procedure.** **Following her transfer back to Good Hope Hospital she developed a high fever on 12th June and by 13th June she had developed sepsis for which she was started on a new course of anti-biotic therapy. There were a limited number of instances of her refusing antibiotic doses between 17th and 20th June but clinicians assessed her as having capacity to make those decisions. On 23rd June her blood tests results showed a deteriorating liver biochemistry which ought to have raised concerns about her liver but her IV paracetamol was continued without further blood tests being repeated. On 27th June her condition deteriorated with confusion and further vomiting with further blood tests indicating she had an acute liver injury, probably contributed to in part by the continued administration of paracetamol.**

	On 28th June she aspirated during an episode of vomiting and as a result suffered a further acute deterioration. She was transferred to ICU where her paracetamol was stopped but despite maximum support she continued to deteriorate. At 2350 hrs on 29th June she suffered a cardiac arrest and despite significant advanced life support being provided to her, she passed away in ICU at 0041 hrs on 30th June 2024. **Evidence was heard at the inquest that there was an absence of an effective multi-disciplinary approach to the management of her complex deterioration especially after the cystogastrostomy and that there were missed opportunities to transfer her to more specialist care either at Heartlands Hospital or Queen Elizabeth Hospital at an earlier stage.** Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Sepsis and Multi Organ Failure** **1b Acute liver failure** **1c Acute Pancreatitis** **1d** **II Malnutrition. Drug induced liver injury. Endoscopic cystogastrostomy**
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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 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.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 18 June 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 : Stephanie Link's next of kin I have also sent it to the Medical Examiner who may find it useful or of interest. 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 or 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	**23rd April 2026** Signature:  **Mr Simon Brenchley** **HM Assistant Coroner** **Birmingham and Solihull**