East Kent
Hospitals University
NHS Foundation Trust

Trust Offices
Kent & Canterbury Hospital
Ethelbert Road
Canterbury
Kent
CT1 3NG
[redacted]

Alison Hewitt

HM Senior Coroner for the City of London

Sent by email

13 August 2026

Dear Ma'am,

Regulation 28 – Prevention of Future Deaths (PFD) Response regarding the inquest into the death of Kerry Singh

This is the formal response on behalf of East Kent Hospitals University NHS Foundation Trust ("the Trust") to the Prevention of Future Deaths report issued following the inquest into the death of Mrs Kerry Singh dated 25 June 2026.

The Trust has carefully considered each concern and taken appropriate action.

Concern 1

Although the need for pacemaker lead extraction at some point was recognised by 2019 at the latest, and although the procedure would necessarily be performed in a tertiary centre, no tertiary centre was consulted or involved in relevant care planning prior to the Deceased's death; there was no such involvement in 2021, when a decision was made to change the pacemaker battery but not the leads, and there was no such involvement subsequently, as the Deceased's condition deteriorated.
The evidence I heard from St. Bartholomew's Hospital was that it is important that the tertiary centre is aware of such patients at any early stage, as this provides an opportunity for the specialist team to understand fully the patient's precise situation, and to plan for an elective procedure to be performed in a timely manner. I heard that the team at St. Bartholomew's Hospital has such early involvement with the hospitals from which referrals are routinely received (which does not include the William Harvey Hospital).

I am concerned that the lack of timely involvement of the relevant tertiary centre in care planning may result in future deaths.

Trust response

The Trust recognises the importance of ensuring that complex cardiac-device cases are identified promptly and, where appropriate, discussed with or referred to a specialist tertiary centre at an early stage.

The Trust Cardiology Service has a well-established Devices MDT through which complex device cases are reviewed. The MDT is responsible for identifying patients in whom lead extraction, lead revision or another specialist intervention may need to be considered and, where appropriate, seeking advice from or making a referral to a specialist tertiary centre.

Following the inquest into Mrs Singh's death, the Terms of Reference for the Devices MDT were formally reviewed and ratified. A Standard Operating Procedure ("SOP") has also been developed and implemented.

The revised governance documents define the purpose and scope of the MDT, responsibilities of attendees, referral criteria, arrangements for recording clinical reasoning and communicating outcomes, circumstances in which tertiary advice should be sought, and the process for allocating, monitoring and escalating MDT actions.

This governance model will also be applied, where appropriate, to other Cardiology Service MDTs.

The Trust recognises that abnormal or deteriorating lead parameters do not invariably require lead extraction. Decisions must be made on an individual basis, taking account of lead behaviour, clinical symptoms, procedural risk, the patient's overall condition and the availability of alternative management strategies.

The purpose of the strengthened MDT and tertiary-referral process is therefore not to mandate extraction. It is to ensure that complex cases are identified consistently, reviewed promptly and, where appropriate, discussed with a specialist extraction centre before the clinical situation becomes urgent.

Review of the 2021 decision

Mrs Singh's case was reviewed in detail at the Cardiology Service Governance Day on 14 July 2026 as part of a multidisciplinary morbidity and mortality review. The review involved 33 members of the wider cardiology team and was multidisciplinary, with representation from medical, nursing, cardiac physiology and operational colleagues.

The review concluded that the decision made in 2021 to replace the pacemaker generator without replacing or extracting the leads was clinically reasonable on the information available at the time.

At that stage, the lead findings had not demonstrated the subsequent pattern of deterioration seen from 2024 onwards. Continued monitoring and device optimisation therefore represented a clinically defensible approach.

The review nevertheless identified opportunities to strengthen the processes surrounding such decisions, particularly by ensuring that the rationale for continued surveillance and the circumstances that would trigger reconsideration or tertiary advice are clearly documented, that MDT outcomes are uploaded promptly to the electronic patient record, and that actions arising from MDT discussion are allocated to a named individual and subsequently confirmed as completed.

MDT action tracking

Although actions arising from MDT discussions were historically recorded on individual referral documentation, the Cardiology Service has now introduced a centralised MDT action log.

The action log records the:

a. patient and case discussed;
b. MDT decision;
c. action required;
d. person responsible for completing the action;
e. target completion date;
f. status of completion; and
g. any requirement for escalation.

Outstanding actions are reviewed at the subsequent MDT meeting and escalated where necessary.

Pending appointment of dedicated administrative support, interim arrangements have been put in place to ensure that the action log is maintained and reviewed. The Specialty Doctor who currently coordinates the Devices MDT provides clinical oversight, with administrative support contributing to the process where available. The proposed MDT Coordinator role is intended to provide a more sustainable arrangement and to ensure that clinical time is focused appropriately on tasks requiring medical input.

Administrative support

The service has developed a job description for a dedicated Cardiology MDT Coordinator.
The proposed role would support the administration of Cardiology MDTs, maintain action logs, monitor completion of agreed actions, ensure that outcomes are uploaded to the electronic patient record and support audit of compliance with MDT processes.

A business case is being prepared for consideration through the Trust's financial-governance processes. In parallel, the Cardiology Operations Team is reviewing existing resources to determine whether funding can be identified through internal reallocation.

The introduction of the action log and formal allocation of interim responsibility mean that the improvements described above are not dependent upon approval of the proposed post.

Further case review

As a further learning action, the Cardiology Service will undertake a multidisciplinary review of Mrs Singh's Emergency Department attendances during the four years preceding her death.
The review will consider whether there were opportunities to:

a. reassess her overall cardiac-device pathway;
b. changes in her clinical condition;
c. seek specialist advice;
d. recognise reconsider the timing of tertiary referral; or
e. improve communication and coordination between the teams involved in her care.

The review will be completed by 2nd October 2026, and reported to the Cardiology Governance Meeting in October 2026. Any further recommendations will be recorded on the service governance action log, assigned to named individuals and monitored to completion.

Concern 2

Further, at the inquest, concern was expressed by the Deceased's family that she was not fully informed and consulted on the question of when the required lead extraction procedure should be performed. There was clear evidence that by late 2024, her condition had deteriorated significantly and that she later expressed her wish to undergo the procedure as soon as possible. There does not appear to be any system in place to ensure that, when it is recognised that a procedure will be needed at some point, the patient is fully involved in the decision making as to when it is performed.

Trust response

The Trust recognises the importance of ensuring that patients are fully involved in decisions where a device or lead problem has been identified that may require future intervention.

The final decision about whether and when to undertake extraction is made by the specialist extraction centre in consultation with the patient. The local Cardiology Service is, however, responsible for ensuring that the patient's concerns and preferences are heard, documented and considered when determining whether specialist advice or referral is required.

The revised Devices MDT SOP requires the clinical plan, where relevant, to document the rationale for continued monitoring, the potential future need for lead revision or extraction, circumstances that should trigger reconsideration or tertiary advice, the information provided to the patient, their questions and preferences, and the arrangements for follow-up. Where a patient reports worsening symptoms, expresses significant concern or wishes to pursue extraction, the case should be escalated for consultant review or discussion at the Devices MDT, with tertiary advice sought where appropriate.

Cardiac physiologists and healthcare scientists remain responsible for assessing device and lead performance and optimising device programming within their scope of practice. Where optimisation is no longer sufficient, lead findings deteriorate, symptoms may be device-related, or significant patient concern is expressed, the case should be escalated through the agreed clinical pathway.

Concern 3

The Deceased's critical test result, which was available from the 31st December 2024, was not accessed by the responsible consultant until March 2025. Further, the decision made subsequently, on the 3rd April 2025, to refer for lead extraction was not acted upon and no referral was made. It is not appropriate for concerns about the clinician to be addressed by means of this PFD Report. However, the failures raise concern also for the systems in place in the William Harvey Hospital. First, in evidence, the clinician suggested that she had not been provided by the Trust with sufficient time in which to perform these tasks and that she was overwhelmed by receiving an unnecessary number of communications. Secondly, I was told that there was no system in place to check that test results have been accessed and read or to alert clinicians to test results which had not been accessed and read, whether through IT alerts or otherwise. Thirdly, it seems that there is no system in place to check that important tasks (such as making a patient referral) have been performed and/or to identify when they have not been performed within a reasonable period.

Trust response

The Trust recognises that the reliable management of abnormal results and important clinical actions requires a closed-loop process. Simply sending a result or communication to a named clinician does not, by itself, provide assurance that the information has been reviewed, acknowledged and acted upon.

The cardiac physiology service has an established SOP governing the identification and escalation of abnormal findings. Following the inquest, this is being revised to strengthen closed-loop communication. The revised process will require abnormal findings to be categorised according to clinical urgency and communicated through an agreed escalation route, identifying the nature and urgency of the finding, the action required and the timeframe for response. Where acknowledgement or an appropriate clinical response is not received within the specified timeframe, the finding will be escalated to an alternative consultant cardiologist or the on-call cardiology team according to clinical urgency. The communication and resulting clinical action will be documented in the electronic patient record. Where appropriate, the cardiac physiologist may also refer the patient directly to the Devices MDT.

Actions agreed through the Devices MDT are now recorded on a central action log, with a named responsible individual and target completion date. Outstanding or overdue actions are reviewed through the MDT process and escalated where necessary. This includes tertiary-centre referrals, investigations, consultant review, changes to follow-up and communication with patients. Where tertiary referral is agreed, completion is confirmed by evidence that the referral has been submitted and recorded.

Consultant cardiologists have programmed time within their job plans for clinical administration, including review of results and correspondence, making referrals and completing associated patient-care tasks. Individual workload and job plans are reviewed through the Trust's established job-planning process. The Trust nevertheless recognises that the provision of administrative time does not remove the need for reliable systems to distinguish urgent clinical information from routine communication and to ensure that important findings and actions are acknowledged and completed.

The Cardiology Service will review implementation of the revised abnormal-results escalation process and compliance with the completion of Devices MDT actions through its established governance arrangements.

Concern 4

A) *Given the seriousness of the omissions by the responsible consultant, which were apparent from her witness statement provided to me in advance of the inquest, I am concerned that the William Harvey Hospital and the Trust did not undertake, prior to the inquest, any internal investigation or review of its care and management of the Deceased, whether by means of a mortality review or otherwise.*

B) *I am concerned that an absence of a system to ensure that serious omissions are investigated and reviewed, independently of the inquest process, will result in failures to make necessary improvements for patient safety and thereby the risk of future deaths.*

Trust response

The Trust accepts the importance of ensuring that material patient-safety concerns identified during preparation for an inquest are considered through the Trust's clinical-governance and patient-safety processes before the inquest takes place.

The Trust has established mechanisms for identifying and reviewing patient-safety concerns. These include mortality review following Medical Examiner scrutiny, patient-safety incident reporting, and concerns identified through complaints, inquests, claims, enquiries from other healthcare providers or other review processes. Within Cardiology, these arrangements are supported by morbidity and mortality review, pacing and device-complication review, multidisciplinary governance meetings, Structured Judgement Review and escalation through the Trust's Patient Safety Incident Response Framework where appropriate.

In Mrs Singh's case, in the absence of a Medical Examiner review or a patient-safety incident report, the Trust recognises that there were missed opportunities for the concerns subsequently identified at inquest to be referred for internal review. These included concerns arising through preparation of the witness evidence and the lack of follow-up after the Trust Patient Safety Team received a request for further information from St Bartholomew's Hospital to support its own patient-safety investigation.

The Trust Patient Safety Incident Response Policy and Plan already recognise that inquest review and preparation may identify patient-safety issues and learning. In order to strengthen the practical application of this requirement, the Trust is reinforcing the expectation that staff, including clinical and legal services, report patient-safety concerns identified during inquest preparation or other review processes so that they can be considered through the appropriate governance route and a proportionate learning response determined. Relevant documents, including witness statements where appropriate, will be made available within the risk-management system to support patient-safety review, and a list of inquest cases will be shared with and reviewed regularly by the Patient Safety Team.

Material clinical concerns identified through review of the medical record, preparation of witness statements, disclosure, legal advice, expert evidence, meetings with witnesses or correspondence from the Coroner or family will therefore be referred to the relevant governance and Patient Safety teams for documented consideration. The response may include a Structured Judgement Review, multidisciplinary case review, thematic review, incident-review process, professional-governance review or another proportionate form of assurance. The decision and any resulting actions will be documented.

Mrs Singh's case was subsequently reviewed at the Cardiology Governance Day on 14 July 2026. The review considered the clinical decisions relating to her pacemaker leads, the timing of tertiary-centre involvement, communication of abnormal findings, patient involvement in decision-making, completion of agreed referrals and actions, and the governance processes that operated before the inquest. The actions arising from that review are reflected in this response.

The Trust will review the effectiveness of the strengthened interface between Legal Services, Divisional Governance and the Patient Safety Team through its established governance arrangements.

Conclusion

The Trust has carefully considered the concerns raised by the Coroner and has undertaken a detailed review of the relevant Cardiology Service processes. The Trust considers that the decision made in 2021 to replace Mrs Singh's pacemaker generator without extracting or replacing the leads was clinically reasonable on the information available at that time.

The Trust nevertheless recognises opportunities to strengthen the systems surrounding complex device management. Changes have been made to the Devices MDT and its governance, tertiary

referral and action tracking, communication and escalation of abnormal findings, documentation of patient involvement, and the interface between inquest preparation and patient-safety governance.

These arrangements will be reviewed through established Cardiology, Divisional and Trust governance processes, with further learning and actions recorded and monitored to completion. The Trust hopes this provides assurance that the Coroner's concerns have been taken seriously and that proportionate action has been taken to reduce the risk of similar events occurring in future.

Yours sincerely

Acting Chief Executive Officer