REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Re: KERRY TERESA SINGH Deceased

1.	**CORONER:** I am Alison Hewitt, HM Senior Coroner for the City of London.
2.	**DATE OF REPORT:** 25th June 2026
3.	**CORONER'S LEGAL POWERS:** I make this report under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	**THIS REPORT IS BEING SENT TO:** **The Acting Chief Executive and Acting Chief Medical Officer of East Kent Hospitals University NHS Foundation Trust.** You are under a duty to respond to this report within 56 days of the date of this report, namely **by the 20th August 2026**. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE:** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations you may wish to make regarding publication of your response. These representations should be made at the same time as the

	response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	**SUMMARY OF CORONER'S CONCERN:** My concerns, which are set out in detail in paragraph 9 below, relate to the management and care of the Deceased's pacemaker problems by the William Harvey Hospital, Kent, and the relevant systems in place within the hospital.
6.	**ACTION SHOULD BE TAKEN:** In my opinion, unless action is taken to address the above concerns (as detailed in paragraph 9 below) then there is a significant risk of future deaths and I believe you have the power to take such action.
7.	**INVESTIGATION AND INQUEST:** On the 16th July 2025, I commenced an investigation into the death of Kerry Teresa Singh, aged 37 years. The inquest was heard on the 22nd and 23rd June 2026. **MY FINDINGS AS RECORDED ON THE RECORD OF INQUEST:** **The medical cause of death:** Ia Bleeding and hypovolaemic shock IbTear of superior vena cava Ic Removal of failing pacemaker II Complete heart block associated with atrioventricular nodal re-entrant tachycardia

How, when and where Kerry Singh came by her death:

Kerry Singh was found to be suffering atrioventricular nodal re-entrant tachycardia in 2014. She was treated at the William Harvey Hospital in Kent where she underwent two unsuccessful ablation procedures, the second of which was complicated by damage to the atrioventricular node connection and consequential complete heart block. As a result, a dual chamber pacemaker was inserted in 2016. There was chronic noise in the pacemaker leads which raised a risk of the Deceased suffering sudden blackout and, by 2019, it was recognised that the leads would need to be replaced. However, when the pacemaker generator was replaced in 2021, due to its early depletion, a decision was made not to replace the leads at the same time. Subsequently, the Deceased continued to suffer episodes of tachycardia and she periodically attended the hospital's emergency department, via ambulance, with symptoms including dizzy episodes and chest pain; by 2023, her symptoms were worsening and by late 2024, her daily functioning was significantly adversely affected. On the 30th December 2024, a 24-hour tape test reported evidence of intermittent failure of the pacing system which increased the risk of sudden blackout, but the report was not viewed by the responsible clinician until March 2025. A multidisciplinary team meeting then took place on the 3rd April 2025 at which it was decided that the Deceased should be referred to a tertiary centre for pacemaker lead removal and replacement, but the responsible clinician did not make the referral. On the 7th July 2025, the Deceased suffered a syncopal blackout because of complete intermittent failure of the pacing system. She was taken by ambulance to the hospital from where she was transferred, on the 11th July 2025, to St. Bartholomew's Hospital, London. On the 14th July 2025, she there underwent urgent lead extraction in the course of which the tip of the ventricular lead released before the sheath was advanced to cover it, causing the sheath to straighten and flick on to the lateral superior vena cava and to tear it. This is a recognised complication of the procedure. Further, post mortem evidence revealed inflammation in the area of the tear and this may have made it more vulnerable to damage. Following the extraction, the Deceased suffered a cardiac arrest as a result of bleeding from the tear. Resuscitation was commenced immediately, and an occlusion balloon was placed, but surgical repair was judged not to be feasible. A pericardial effusion developed and was drained but, despite all efforts, cardiac output could not be restored. Consequently, resuscitation was stopped and the Deceased's death was confirmed at 13.10 hours on the 14th July 2025.

There was delay in referring the Deceased for the extraction procedure but it is not possible to know whether her death would have been avoided if the procedure had been performed at an earlier date or on an elective basis.

Conclusion as to the death:

Died as a result of a recognised complication of a necessary procedure which was performed to remove and replace a failing medical device.

8.	**CIRCUMSTANCES OF DEATH:** As stated above, Kerry Singh was under the care of the William Harvey Hospital for over ten years. A dual chamber pacemaker was inserted in 2016 and quite soon thereafter it was known that there was noise in the pacemaker leads, due to failure of their insulation, and that this raised a risk of intermittent failure of the pacing system, By 2019 at the latest, it was recognised that the leads would need to be replaced at some point and that this would have to be performed by a specialist tertiary centre. I was told that it was good practice to wait to perform the procedure until a generator change was needed but that, when the pacemaker generator was in fact replaced in 2021 (due to its early depletion), a decision was made not to replace the leads at the same time. No tertiary centre was consulted or involved in this decision making. Subsequently, the Deceased continued to suffer episodes of tachycardia and she periodically attended the hospital's emergency department, via ambulance, with symptoms including dizzy episodes and chest pain. By 2023, her symptoms were worsening and by late 2024, her daily functioning was significantly adversely affected, such that she was unable to work. She complained regularly of chest pain, which extended into surrounding areas, the cause of which was not identified. The Deceased was reviewed periodically in the hospital's pacemaker clinic. In October 2024, on the basis of the pacemaker's data, the clinic had concerns about its performance and a 24-hour tape test was arranged. The result of that test provided evidence that intermittent failure of the pacing system was occurring and this increased the already recognised risk of sudden blackout. The test result was provided to the responsible consultant on the 31st December 2024 but she did not view it until March 2025. A multidisciplinary team meeting then took place on the 3rd April 2025 at which it was decided that the Deceased should be referred to a tertiary centre for pacemaker lead removal and replacement as no programming options to address the lead noise issue remained. However, the referral was not made by the responsible consultant. On the 7th July 2025, the Deceased suffered a syncopal blackout because of complete intermittent failure of the pacing system. She was taken by ambulance to the hospital where, on the 10th July 2025, it was discovered that the Deceased ought to have been referred to a tertiary centre but that no referral had been made. On the 11th July 2025, she was transferred on an urgent basis to St. Bartholomew's Hospital, London. On the 14th July 2025, she underwent urgent lead extraction which, she was told by the consultant at Barts, "should have happened five years earlier". In the course of the procedure, iatrogenic damage was caused to the superior vena cava and this led to bleeding and the Deceased's death following unsuccessful resuscitation efforts.

	I concluded that there was delay by the William Harvey Hospital in consulting and making a referral to a tertiary centre, which deprived the Deceased of the benefit of specialist input at an early stage and the possibility of the lead extraction being performed at an earlier stage and on an elective basis. However, given that her death resulted directly from a catastrophic recognised complication in the procedure, I also concluded that it was not possible to know whether, in the Deceased's case, death would have been avoided if the procedure had been performed at an earlier time or on an elective procedure.
9.	**CORONER'S CONCERNS:** In the course of the inquest, I heard evidence giving rise to concerns. 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: **Concern 1** 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. 2. 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). 3. I am concerned that the lack of timely involvement of the relevant tertiary centre in care planning may result in future deaths. **Concern 2** 4. 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. **Concern 3** 5. 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. **Concern 4** 6. 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. 7. 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.
10.	**COPIES AND PUBLICATION OF THIS REPORT:** I have a duty to send a copy of my report to every Interested Person who, in my opinion, should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. **The Family of Kerry Teresa Singh**

	2. Barts Health NHS Trust I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE: **Alison Hewitt**