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).

1.	**CORONER** I am Mrs Joanne Lees, the Area Coroner for The Black Country Jurisdiction.
2.	**DATE OF REPORT** 28 August 2026
3.	**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.	**THIS REPORT IS BEING SENT TO** 1. **Sandwell and West Birmingham NHS Trust** You are under a duty to respond to this report within 56 days of the date of this report, namely by **23rd October 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 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**

	I am concerned that there is an ongoing risk of future deaths where clinical staff are required to make treatment decisions, undertake invasive procedures, or provide clinical advice without access to relevant medical records and previous medical history held by other NHS Trusts.
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 22 August 2025 I commenced an investigation into the death of Mr **Hugh Hyvester RUDDER** who died on 14 August 2025 at New Cross Hospital Wolverhampton. The medical cause of death was Cause of death 1a Sudden Adult Cardiac Death Cause of death 1b Coronary Artery Atherosclerosis and Left Ventricular Hypertrophy Cause of death II Recent Urethral Catheterisations and blood loss, Type 2 Diabetes Mellitus, Essential Hypertension **How, when and where** Mr Hugh Hyvesta RUDDER died at New Cross Hospital, Wolverhampton on 14 August 2025. His death was due to sudden adult cardiac death on a background of coronary artery atherosclerosis and left ventricular hypertrophy. Recent catheterisation procedures and resulting haematuria contributed to death by precipitating the fatal cardiac event. **Conclusion at inquest** Narrative - Mr Rudder's death was precipitated by the recent catheterisation procedures and resulting haematuria
8.	**CIRCUMSTANCES OF DEATH** Mr Hugh Rudder was an 81-year-old gentleman with a recent background of urine retention and catheter insertion. He underwent a planned urethral catheter change in the community on 13 August 2025 which was successful on the 2nd attempt. Later that day he developed haematuria and clot retention was admitted initially to Walsall Manor Hospital ED but transferred to New Cross Hospital where Urology Services were based. At New Cross Hospital, a 3 way catheter was inserted to manage and prevent further clots. Shortly after the procedure, Mr Rudder became unresponsive. He suffered a cardiac arrest and could not be resuscitated and died in Hospital on 14 August 2025. His death was due to sudden adult cardiac death on a background of coronary artery atherosclerosis and left ventricular hypertrophy. The recent catheterisation procedures and resulting haematuria contributed to death by precipitating the fatal cardiac event.

9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: 1. Sandwell and West Birmingham NHS Trust provided its Clinical Guideline for Urethral Catheterisation within Acute and Community Settings. Section 3.5.1 requires a nurse practitioner in the community to stop the procedure and seek medical advice where a catheter cannot be easily passed because of the risks posed to the patient. This did not occur during Mr Rudder's catheter change. 2. I heard evidence that community nurse practitioners do not have access to a patient's medical records and previous medical history where those records are held by another NHS Trust. In Mr Rudder's case, relevant records were held by Walsall Healthcare NHS Trust whilst the catheter change was undertaken by staff employed by Sandwell and West Birmingham NHS Trust. 3. I am concerned that community practitioners may be undertaking invasive procedures without access to relevant medical records or previous clinical history held by another Trust. 4. I am concerned that community practitioners appear to be required by local guidance to seek clinical advice where they do not have access to relevant medical records or previous clinical history held by another Trust. 5. I am further concerned that the clinicians from whom advice is sought may themselves lack access to those records and therefore be required to provide clinical advice without the benefit of potentially relevant information concerning the patient's medical history, previous catheterisation difficulties, underlying conditions or prior treatment. 6. The evidence heard at inquest suggests that limitations on the sharing and accessibility of patient records across NHS Trust boundaries may hinder informed clinical decision-making during invasive procedures and when responding to complications arising from those procedures. 7. Taken together, these matters give rise to a concern that there remains a risk of future deaths unless effective arrangements are in place to ensure that clinicians are able to access, or readily obtain, relevant medical records and clinical history when providing treatment to patients whose records are held by another NHS Trust.
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 the family of the deceased 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 