ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health** **2. Barts Health NHS Trust** **3. Brompton NHS Trust**
1	**CORONER** I am Dr Julian Morris, assistant coroner, for the coroner area of Inner London South
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** An investigation into the death of Mr Harold Chapman, aged 34, was opened following Mr Chapman's death on 14 June 2016. The investigation concluded at the end of the inquest on 27 October 2017. The conclusion of the inquest was a narrative conclusion which covered, in summary, the following: Mr Chapman had been diagnosed with Hypertrophic Cardiomyopathy (HCM) in 2009, and referred to a specialist team in 2010. His reviews and treatment from early 2010 to May 2015 were unremarkable and his risk stratification was low. In August 2015, he developed non-sustained ventricular tachycardia (NSVT) present in 2 holter readings (August and December 2015). The consultant requesting the August trace did not review it. It was reviewed by a clinical fellow in November 2015 who considered it to be unequivocal. Subsequent review in 2016 confirmed the presence of NSVT and a significant increase to Mr Chapman's risk factors for an episode of a more significant arrhythmia and subsequent sudden cardiac death. A further holter trace in December 2015 also revealed NSVT; this was not reviewed until it was seen by a new team in April 2016. Following the review in April 2016, he was referred for consideration of an ICD implant which would deliver a shock should he develop sudden arrhythmia (ventricular tachycardia or ventricular fibrillation). The chances of survival of an out of hospital cardiac arrest were low. His risk stratification in April 2016 was 8.7% and warranted consideration of the implant. I considered Mr Chapman died as a result of natural causes but that the care provided to him in/around August and November 2015 was such that it amounted to a gross failure to provide basic care for his condition and his risk stratification and the subsequent insertion of an ICD to treat and prevent a sudden cardiac death incident.

4	**CIRCUMSTANCES OF THE DEATH** Mr Chapman had been diagnosed with Hypertrophic Cardiomyopathy (HCM) in 2009, and referred to a specialist team in 2010. His reviews and treatment from early 2010 to May 2015 were unremarkable and his risk stratification was low. The Trust were aware of Mr Chapman's condition and its possible complication having been central to the development and implementation of the ESC Guidelines in 2014 on the management and treatment of individuals with HCM. The development of NSVTs increases an individual's risk stratification and the percentage chance of having a sudden cardiac death arrhythmia. Such an arrhythmia can only be treated by way of delivery of an electrical shock. If a shock is not delivered within minutes the chances of survival are low. The ICD delivers that shock. The waiting time for an ICD insertion, having passed through the various reviews and assessments around the time of Mr Chapman's death was 6 months. Following the holter trace in August 2015, this was not reviewed by the consultant; it showed a run of NSVT. He was reviewed in the clinic in November 2015, it was deemed unequivocal. No action was taken and the failure had a direct and clear causal connection with Mr Chapman's death. Statistically there was no way of knowing if and when Mr Chapman might have had a significant arrhythmia. At the time of his death he had opted for and was on the waiting list for assessment of an ICD following review of the same August trace. In all the circumstances the missed opportunity more than minimally, negligibly or trivially contributed to Mr Chapman's death. Rendering that treatment, at the earlier time would, on balance, have saved Mr Chapman's life when he had the arrhythmia in June 2016.
5	**CORONER'S CONCERNS** 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, the evidence revealed during his dealings with the Barts NHS Trust and, more specifically the lead consultants, emails were passed by Mr Chapman to the consultants. It became clear during the inquest that those emails were often not viewed and/or acted upon and as a result no response was received by the patient. It is fully appreciated that consultants are busy with their clinical responsibilities covering wards, clinics and on-calls. However, if contact details are provided for 'direct access' to individual doctors/consultants, it seems obligatory that those should be viewed, acknowledged and patients responded to. Patient contact with medical professionals, not just hospital related, is an important part of modern medical practice. Whilst this is a huge task, it would seem possible to come up with either National or local guidelines in respect of the use of all forms of communication between patients and their clinician (covering phone and emails).

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 Wednesday 13th February 2017. 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 [redacted] 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. He may send a copy of this report to any person who he 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	**28 November 2017** **Dr Julian Morris**