ANDREW BARKLEY
LL.B, Hon DUniv
HER MAJESTY'S CORONER

for the
Stoke-on-Trent and North Staffordshire
Coroner's Area

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Good Hope Hospital, Rectory Road, Sutton Coldfield, B75 7RR** **Burton Queens Hospital. Belvedere Road, Burton-upon-Trent, DE13 0RB** **Darwin Medical Practice, St Chad's Health Centre, Dimbles Lane, Lichfield, WS13 7HT**
1	**CORONER** I am Margaret J Jones HM Assistant Coroner for **Stoke-on-Trent & North Staffordshire**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 15/03/2019 I commenced an investigation into the death of Geoffrey Duke. The investigation concluded at the end of the inquest 14th May 2019. The conclusion of the inquest was: The deceased had a history of asthma and diabetes. He was allergic to penicillin. Following complete heart block a pacemaker was fitted in 2007. He underwent routine box change at Good Hope Hospital, Birmingham on the 15th June 2016 requiring an additional lead. He became unwell and was treated at Good Hope in February 2017 with a diagnosis of bronchopneumonia. He was unwell again and treated at Burton Queens Hospital in August 2017 with a diagnosis of sepsis of unknown source. No consideration was given on either occasion to the possibility of the pacemaker as the source of infection. He was readmitted to Burton Queens Hospital on the 16th October 2017. An echocardiogram on the 18th October 2017 found significant vegetation on the pacemaker wires. It is likely that the infection had occurred at the time of the pacemaker box change and that he had been suffering with undiagnosed endocarditis for some months. He was transferred to the Royal Stoke University Hospital, Stoke-on-Trent on the 1st December 2017. Whilst awaiting pacemaker wire extraction he was treated with antibiotics which caused a skin reaction. Tests showed the vegetation had increased in size. He became very unwell and surgery was carried out on the 5th December 2017. During surgery a small amount of pacemaker insulation striped off and remained adherent to the left subclavian vein. Five days post operatively he deteriorated with signs of a severe drug reaction likely due to the vancomycin treatment. His drugs were changed. He continued to deteriorate and died at the hospital at 9.36 pm on the 20th December 2017.
4	**CIRCUMSTANCES OF THE DEATH** See above.
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. – Mr. Duke underwent pacemaker box change on 15th June 2016. He was subsequently unwell on a number of occasions. He visited Good Hope Hospital on 6th February 2017, his GP on a number of occasions and Burton Queens Hospital in August 2017. No consideration appears to have been given that the pacemaker box change may have been the source of his undiagnosed infections. No referral was made to a Cardiologist. His problem was diagnosed on his first admission on 27th October 2017. At inquest there was no evidence of a referral process for patients having undergone pacemaker surgery who subsequently become unwell.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Good Hope Hospital, Burton Queens Hospital and Darwin Medical Practice 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 **Friday 26th July 2019**. 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: 1. The Chief Coroner 2. [redacted] (widow of the deceased) 3. [redacted] daughter of the deceased 4. [redacted] Healthcare Governance Manager Patient Safety, University Hospiital of North Midlands 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	30th May 2019 Signature pp. Margaret J Jones HM Assistant Coroner **Stoke-on-Trent & North Staffordshire**