

Agenda Item: 3.ii

Report to:	Board of Directors	Date: 5 th March 2026
Report from:	Chief Nurse and Medical Director	
Trust Objective/Strategy:	GOVERNANCE: Patient Safety, Effectiveness of Care, Patient Experience and DIPC	
Title:	COMBINED QUALITY REPORT	
Board Assurance Framework Entries:	Unable to provide safe, high-quality care BAF numbers: 675	
Regulatory Requirement:	CQC Regulation 12 Safe care and treatment NQB: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care	
Equality Considerations:	None believed to apply	
Key Risks:	Non-compliance resulting in poor outcomes for patients and financial penalties	
For:	Information	

1. Purpose:

The Medical Director and Chief Nurse would like to highlight the following items in addition to the Papworth Integrated Performance Report (PIPR) to the Board:

2. Inquests/Pre-Inquest Review Hearings – December 2025

- Two inquests were heard in December 2025 – neither required attendance by RPH staff.
- The Trust attended one Pre-Inquest Review Hearing (PIRH) in December 2025. The first inquest has been listed for 5 days in March 2026 and RPH will be represented by our legal team. The second is due to be heard in April 2026 for one day.
- *The purpose of these hearings is for all interested parties to meet and agree the scope of the future inquest.*
- The Trust was notified of nine new inquests/coroner’s investigations in December 2025 and statements have been requested from clinicians and clinical records provided to the Coroner.
- There are currently 81 Coroner’s investigations/inquests outstanding (as at 31/12/25).

Patient A (Cambridge & Peterborough Coroner) – RPH not an Interested Person (IP) and no attendance required.

Background:

Patient had a diagnosis of Duchenne Muscular Dystrophy, a serious muscle wasting disease, which adversely impacted both their respiratory and cardiac function. In December 2022 they tested positive for Covid-19 and 2 days later were admitted to their local hospital having become increasingly unwell. They required a blood transfusion for a suspected gastrointestinal bleed and were also treated with antibiotics for infection. A few days later an ECG identified a

significant decline in their cardiac function. Four days after this, the patient went into cardiac arrest and despite attempts at resuscitation, died.

Post mortem examination confirmed they died as a consequence of their underlying natural disease. Death would have been hastened by contracting covid 19 which predisposed them to a subsequent pneumonia.

Medical Cause of Death:

- 1a) Pneumonia and cardiomyopathy
- 1b) Duchenne muscular dystrophy

Coroner's Conclusion:

Natural causes.

Patient B (Essex Coroner) – RPH not an Interested Person (IP) and no attendance required.

Background:

Patient had received treatment for bronchiectasis under the care of the Lung Defence Clinic at Royal Papworth Hospital since 2012. Although stable from a respiratory perspective, they were having ongoing problems with low mood and were seen by a Consultant Psychiatrist at RPH and a Specialist Community Mental Health team due to concerns about the impact of their mental health problems on food/fluid intake, physical health and general deconditioning. Patient died at their local hospital in September 2024.

Medical Cause of Death:

- 1a) Malnutrition
- 1b) Eating Disorder
- 2) Infective exacerbation of bronchiectasis, severe depression.

Coroner's Narrative Conclusion: Awaited

Inquests/Pre-Inquest Review Hearings – January 2026

- Three inquests were heard in January 2026, all required attendance by RPH staff.
- RPH was legally represented by a barrister at one inquest and six Papworth clinicians attended to give evidence in person over two days. The other two inquests each required attendance by a Consultant, one in person and one remotely.
- The Trust was not required to attend any Pre-Inquest Review Hearings (PIRH) in January 2026. The purpose of these hearings is for all interested parties to meet and agree the scope of the future inquest.
- The Trust was notified of eight new inquests/coroner's investigations in January 2026 and statements have been requested from clinicians and clinical records provided to the Coroner.
- There are currently 86 Coroner's investigations/inquests outstanding (as at 31/01/26).

Patient C (Cambridgeshire & Peterborough Coroner)

Background:

Patient had a significant past medical history including cardiac disease, alcohol excess with associated liver cirrhosis, bowel perforation and depression all of which resulted in them becoming increasingly frail. Patient suffered a fall at home. They were visited at home by a healthcare assistant from their GP practice for routine blood tests and observations to be carried out. Patient was noted to be wheezy and in significant pain and so was taken by ambulance to hospital. A CT scan carried out identified bilateral rib fractures, a collapsed lung and air trapped

around their heart and oesophagus. Patient's breathing function declined and they went on to develop pneumonia. Sadly, despite care and treatment, their condition worsened, adversely impacted by general frailty and poor health, and patient died in hospital two weeks later.

Royal Papworth Hospital evidence:

Patient had heart attack in 2020, elective coronary artery bypass surgery and mitral valve repair 2022. Slow progress with anaemia and residual mitral valve regurgitation. Recommendation to GP for optimisation of cardiac medications but could not happen due to other conditions being treated. Consultant required to give evidence for background information and clarification in relation to mitral valve repair not replacement. These were answered at inquest.

Medical Cause of death:

- 1a) Multiorgan failure
- 1b) E coli pneumonia
- 1c) Traumatic haemopneumothorax with pneumomediastinum
- 2) Ischaemic and valvular heart disease, alcohol related liver cirrhosis, frailty

Coroner's Conclusion:

Accident

Patient D (Cambridgeshire & Peterborough Coroner)

Background

Patient had a background of dilated cardiomyopathy with severely impaired left ventricular function.

Patient was placed on the routine waiting list for a heart transplant in March 2022. They continued to deteriorate as an outpatient and were admitted to RPH eight months later where they were treated to normalise their end organ function in order to remain active on the transplant waiting list. They became eligible for prioritisation on the national urgent waiting list.

Patient required further escalation of treatment to temporary mechanical biventricular support (BIVAD). Following recovery of their end organ function, they were reactivated on the national super urgent waiting list. They had periods 'on hold' from the waiting list with intercurrent infection. After a period of stability patient was placed on the national super urgent waiting list. Patient had two Ventricular Assist Device (VAD) circuit changes in line with the manufacturer's guidance for circuit change, the first was early in 2023 and the second was two months later. Both circuit change procedures (the procedure(s)) were conducted uneventfully with full flow rate being returned and no issues or concerns arising. Full checks were carried out during the procedures to ensure that the VAD circuit was functioning within normal clinical parameters and flow rate was achieved in line with clinical parameters.

Two days after the second circuit change, there was a disconnection of one of the patient's external Left Ventricular Assist Device (LVAD) circuit pipes resulting in a catastrophic acute blood loss and cardiac arrest. Patient was resuscitated with massive transfusion and temporary conversion to a hybrid circuit. A CT head scan the following day showed extensive intra-vascular thrombosis. The CT head scan findings were incompatible with recovery and that ongoing support was futile. Mechanical Circulatory Support was withdrawn after discussion with their family.

There is no evidence that the disconnection of the VAD could have been predicted or prevented; there is no evidence that the disconnection was caused or contributed to by a human error or mechanical failure or defect.

It is not possible to say how the disconnection occurred.

Medical Cause of Death:

- 1a) Multi-organ failure
- 1b) Severe haemorrhage from disconnected biventricular device line
- 1c) Dilated cardiomyopathy

Coroner's Conclusion:

Died from a catastrophic haemorrhage as a result of the disconnection of his Left Ventricular Assist Device (LVAD) circuit whilst receiving treatment at Royal Papworth Hospital for advanced heart failure due to idiopathic dilated cardiomyopathy and awaiting cardiac transplantation. The cause of the disconnection of the LVAD circuit is unknown.

Coroner's request for further information after inquest:

1. Letter from Royal Papworth Hospital to HM Coroner which explains how the Trust decides what is reportable to the Medicines and Healthcare products Regulatory Agency (MHRA) and any associated policies which underpin this decision making.
2. Letter from Royal Papworth Hospital to HM Coroner which explains what further briefing will happen at national meetings and what this briefing will include.

Patient E (Cambridgeshire & Peterborough Coroner)

Background

Patient was admitted to Royal Papworth Hospital in late 2024 where an angiogram showed critical left sided coronary artery disease. They underwent urgent coronary artery bypass graft surgery and were admitted to Intensive Care in a stable condition. Patient made a reasonable recovery initially, suffering some brief vasovagal episodes which were monitored with echocardiograms which demonstrated no concerning features.

A week later, patient was observed to lose consciousness on standing up before suffering a cardiac arrest. Their chest was reopened on the ward to reveal a pericardial effusion which when released led to a return of spontaneous circulation. Patient was taken back into the operating theatre but suffered a further cardiac arrest and was placed on cardiopulmonary bypass. During the emergency cannulation for the bypass, they suffered a traumatic injury to the aortic arch, resulting in an aortic dissection, haemorrhage and left haemothorax. It was recognised that the situation was irrecoverable and patient passed away that day.

Medical Cause of Death:

- 1a) Haemothorax
- 1b) Acute aortic dissection
- 1c) Ischaemic heart disease (operated on)

Coroner's Conclusion:

Died from recognised complications of necessary life-saving surgery where the emergence of pericardial tamponade was not detected prior to cardiac arrest but where it is not possible to say on the balance of probabilities that earlier detection would have prevented the deterioration and death.

3. Recommendation

The Board of Directors is requested to note the content of this report and its appendices.