Agenda item: 4.ii

Report to:	Board of Directors	Date: 6th November 2025
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 – August 2025

- Two inquests were heard in August 2025 - only one required attendance by RPH staff and RPH were legally represented. Two Consultant Cardiothoracic surgeons and a Consultant in Cardiothoracic Anaesthesia and Critical Care from the Trust attended in person to give verbal evidence at the inquest.

- The Trust was not required to attend any Pre-Inquest Review Hearings (PIRH) in August 2025.

- The Trust was notified of four new inquests/coroner's investigations in August 2025 and statements have been requested from clinicians and clinical records provided to the Coroner.

There are currently 82 Coroner's investigations/inquests outstanding (as at 31/08/25).

Patient A (Essex Coroner) – No attendance required

Background:
Patient underwent successful surgery for aortic valve disease at their DGH and was being treated in intensive care. A referral was made and advice given from the Extracorporeal Membrane Oxygenation (ECMO) and Severe Acute Respiratory Failure (SARF) service at Royal Papworth Hospital on treatment and proning, some improvement was noted. The patient suffered pulmonary haemorrhage following iatrogenic injury to the lung during chest drain insertion under guidance that caused a blood clot in the left bronchial tree and this led to their death. This was in a background of degenerative calcific mitral valve disease.

Medical Cause of death:

1a) Blood clot of the left bronchial tree
1b) Pulmonary haemorrhage following iatrogenic injury to lung during chest drain insertion
1c) Aortic valve disease (operated on)
2) Degenerative calcific mitral valve disease

Coroner's Conclusion:

Sustained an iatrogenic injury to the left lung during attempted chest drain insertion resulting in lung haemorrhage and was not suitable for ECMO.

Patient B (Cambridgeshire & Peterborough Coroner)

Background

Patient underwent a bilateral lung transplant and atrial septal defect (ASD) operation on a background of idiopathic pulmonary hypertension. They had been placed on the transplant waiting list nine months earlier. The transplant operation was extremely complex, difficult and long and post operatively the patient required extra corporeal membrane oxygenation life support (ECMO). The donor lungs showed evidence of areas which were expected to recover following transplantation and were deemed suitable for transplant and demonstrated an appropriate level of function. Post operatively the patient suffered a number of infections including pneumonia, candidia hyperammonaemia, Vancomycin Resistant Enterococcus (VRE). They required further major surgery to address anastomosis which had not responded to non-surgical intervention. The patient was placed on ECMO following this second major surgery to support their heart and lungs in recovery. A further microbiological finding of VRE bacteriemia was identified. They remained in end stage of renal failure fully dependent on renal replacement dialysis. Despite ongoing maximal support the patient's condition continued to deteriorate.

Medical Cause of death:

1a) Multi-organ failure
1b) Primary graft dysfunction and sepsis
1c) Bilateral lung transplant for pulmonary hypertension
2) Donor related organising aspiration pneumonia

Coroner's Conclusion:

Narrative Conclusion: Died as a result of the recognised complications of necessary elective medical procedures.

Inquests/Pre-Inquest Review Hearings – September 2025

- Two inquests were heard in September 2025 which required attendance by RPH staff. Due to lack of cover available within the Clinical Governance team, RPH were legally represented at both.

- Of note, inquest for Patient C – patient died in 2018 and was the Trust's oldest open inquest. A Consultant Cardiologist from the Trust was called to give evidence at the inquest.

- For Patient D, a Consultant Interventional Cardiologist attended to give evidence.

- The Trust was not required to attend any Pre-Inquest Review Hearings (PIRH) in September 2025. There was one held which involved an RPH patient but the Trust was not given Interested Person (IP) status and therefore did not attend. *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 five new inquests/coroner's investigations in September 2025 and statements have been requested from clinicians and clinical records provided to the Coroner.

There are currently 73 Coroner's investigations/inquests outstanding (as at 30/09/25).

Patient C (Cambridgeshire & Peterborough Coroner)

Background:
Patient was diagnosed with heart failure due to dilated cardiomyopathy in 2010. They were fitted with a cardiac resynchronisation therapy device (CRT-D) in 2012 and remained stable on heart failure medication until 2016. They were prescribed Entresto in August 2016 at their annual cardiac review and remained stable on this medication until September 2017 when they were reviewed in the Heart Failure Nurse led clinic. Blood tests revealed liver and kidney dysfunction and urgent scans disclosed this was due to progressive heart failure.

Patient was seen by their Consultant Cardiologist who noted a rapid decline in their end organ function due to heart failure and referred them to RPH for consideration of Heart Transplantation. Patient was admitted to RPH December 2017 where they were described as catastrophically unwell with fast heartbeat, fluid overload and end organ dysfunction requiring urgent and intensive support treatment. A multi-disciplinary team meeting determined that their prognosis was very poor with survival at days to weeks. Patient was not fit for heart transplantation due to end organ dysfunction and required a period of mechanical circulatory support (MCS) to allow end organ recovery followed by an urgent heart transplant. An intra-aortic balloon pump inserted showed no improvement after 48 hours. Three days later they underwent a left ventricular assist device (LVAD) implantation followed by insertion of a Protek Duo cannula to provide right ventricular mechanical assistance (RVAD). Post operatively patient suffered a number of serious complications including worsened coagulopathy, bleeding from an unknown source, superior vena cava (SVC) obstruction due to the Protek Duo cannula and pacing leads from their pacemaker. The patient was taken back to surgery to fix the obstruction.

The patient's end organ function did not improve and they were taken back to surgery to remove the Protek Duo cannula and replace with extra corporeal RVAD. Their end organ function showed signs of improvement. Their condition continued to decline over the coming days and blood tests revealed a viral infection. The patient may not have died when they did had consideration been given by the RPH MDT to earlier intervention by way of MCS and post operative removal of the Protek Duo cannula.

Medical Cause of death:
1a) Pneumonia and herpes simplex viraemia
1b) Complications of ventricular assist device placement
1c) Dilated cardiomyopathy

Coroner's Conclusion:
Died from the known complications of lifesaving surgery. Patient may not have died when they did if earlier mechanical circulatory support and conversion to conventional RVAD from PTD had been considered by the surgical team.

Patient D (Cambridgeshire & Peterborough Coroner)

Background
Patient had a longstanding history of rheumatoid arthritis, congestive heart failure and mobility problems though they maintained an independent lifestyle.

In late 2023, after several years of increasing episodes of breathlessness and fluid overload due to heart failure, the patient underwent a transcatheter edge to edge repair (TEER) procedure at the Royal Papworth Hospital to place clips on the mitral valve to reduce mitral regurgitation. The initial procedure was performed without incident and patient was discharged home with a plan for a follow-up review after 8-12 weeks.

Over Christmas, the patient continued to experience some breathlessness which worsened in the New Year and having undergone blood tests which showed very low haemoglobin levels, their GP sent them to the Emergency Department (ED) of Peterborough City Hospital in mid January 2024 for a blood transfusion. Patient was admitted after considerable time waiting to be seen, and subsequent tests revealed that they had a folate deficiency as well as other incidental conditions such as gallbladder inflammation, DVT and multiple subacute bony fractures. They also had signs of haemolysis and their anaemia failed to respond despite repeated transfusions and antibiotics. The patient continued to decline and passed away a week later.

Post mortem examination revealed that the mitral clips had become displaced, allowing the mitral regurgitation to resume and lead to heart failure.

Medical Cause of Death:

1a)	Heart failure
1b)	Mitral valve regurgitation (Mitral valve clips in December 2023) with secondary haemolytic anaemia
1c)	Papillary Muscle Rupture
2)	Rheumatoid arthritis; acute-on-chronic renal impairment

Coroner's Conclusion:
Died from heart failure following a mitral valve procedure where, on the balance of probabilities, the mitral clips were displaced spontaneously at an unknown point by excessive motion in the leaflets, allowing mitral valve regurgitation to recur. There is no identifiable act or omission which caused or contributed more than minimally to the death, which occurred on a background of multiple, significant co-morbidities.

3. Recommendation

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