Agenda Item: 3.ii

Report to:	Board of Directors	Date: 8th January 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 – October 2025

- Two inquests were heard in October 2025 – neither required attendance by RPH staff.
- The Trust attended one Pre-Inquest Review Hearing (PIRH) in October 2025. Further statements have been requested by the Coroner following this and the inquest is due to be listed next year. *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 four new inquests/coroner's investigations in October 2025 and statements have been requested from clinicians and clinical records provided to the Coroner.
- There are currently 75 Coroner's investigations/inquests outstanding (as at 31/10/25).

Patient A (Cambridge & Peterborough Coroner) – No attendance required

Background:
The patient was referred to RPH in 2023 due to a right sided pleural effusion and underwent a medical thoracoscopy. Multiple pleural biopsies were obtained which confirmed a diagnosis of epithelioid mesothelioma. The patient was advised this was not a curable disease. They were referred to a medical oncologist at their DGH for consideration of potential immunotherapy or standard chemotherapy treatment but it was uncertain whether they would be a candidate for either of these due to their age and previous medical history of Crohn's Disease.

The patient died at home three months later. Their death resulted from right epithelioid mesothelioma that was caused by exposure to asbestos dust in the workplace.

Medical Cause of death:

1a) Right Epithelioid Mesothelioma
2) Cerebrovascular disease, Crohn's disease, Chronic heart failure

Coroner's Conclusion:
Industrial disease

Patient B (Cambridgeshire & Peterborough Coroner) – Written inquest, no attendance required.

Background:
Patient was referred to RPH in March 2023 for consideration of surgical aortic valve replacement. They were reviewed in surgical outpatient clinic and provisionally accepted for aortic valve replacement pending a CT coronary angiogram. A further CT coronary angiogram was requested by RPH and took place four months later. A further surgical outpatient review was scheduled three months after this with the patient being added to the elective surgical waiting list in early 2024. On admission in May 2024, patient was found to be in congestive heart failure. A repeat transthoracic echocardiogram showed critical aortic stenosis, severe mitral regurgitation, moderate tricuspid regurgitation and severely impaired biventricular function, which was a significant deterioration compared to previous echocardiogram four months earlier (January 2024).

Medical Cause of Death:
1a Critical aortic stenosis
1b Severe biventricular failure
II Hypertension, chronic obstructive pulmonary disease, cerebrovascular accident

Coroner's Narrative Conclusion:
Patient died whilst waiting for surgical intervention on the Royal Papworth Hospital elective surgical pathway. The patient was referred to RPH in March 2023, provisionally accepted for aortic valve replacement surgery in May 2023.*

When the patient was admitted to RPH in May 2024 to undergo the procedure, the patient's condition had deteriorated to the extent that was no longer suitable for surgical aortic valve replacement.

*The patient was finally accepted for surgery in December 2023 after coronary angiograms at the local hospital.

Inquests/Pre-Inquest Review Hearings – November 2025

- Two inquests were heard in November 2025, one required attendance by RPH staff (see concluded inquest details).

- The Trust attended one Pre-Inquest Review Hearing (PIRH) in November 2025 (INQ2324-06/ID448). The inquest is due to be heard for 2 days 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 three new inquests/coroner's investigations in November 2025 and statements have been requested from clinicians and clinical records provided to the Coroner.

- There are currently 75 Coroner's investigations/inquests outstanding (as at 30/11/25).

Patient C (Cambridgeshire & Peterborough Coroner) – No attendance required, inquest in writing.

Background:
Patient presented to their local Hospital in December 2019 with a suspected ST-elevation myocardial infarction (STEMI). A diagnostic coronary angiogram showed stenosis in the left main stem. The patient underwent Percutaneous Coronary Intervention (PCI) to stent their left main stem stenosis. The PCI procedure was difficult and unsuccessful and the stent became dislodged and was recovered from the left femoral artery. A further attempt at angioplasty was unsuccessful. A discussion was held with Royal Papworth Hospital (RPH) to consider a transfer of care and for coronary bypass surgery. The patient was not sufficiently well for transfer at that time with a suspected infection and a decision was made to continue to manage their care locally.

They were transferred to RPH three days later after CT scan demonstrated type A aortic dissection. Patient transferred straight to RPH theatres for cardiac surgery. On induction of the anaesthetic the patient's condition declined with low cerebral saturation and hypotension, they suffered a cardiac arrest and needed internal massage. Whilst cardiopulmonary bypass was established, patient was noted to have dilated pupils and poor contraction of their heart. A decision was made to withdraw further intervention with agreement from all the consultants present due to the futility of continuing.

The postmortem examination concluded that the patient died as a result of complications of their acute aortic dissection. The patient's local hospital (not RPH) conducted a serious investigation report (SIR) which found that there was a delay in the recognition and diagnosis of patient's aortic dissection because aortic dissection was not considered as a possible differential diagnosis. Earlier recognition would have given them a better chance of a more favourable outcome.

Medical Cause of death:
1a) Acute aortic dissection

Coroner's Conclusion:
Died as a result of complications of acute aortic dissection. Recognition of the condition between patient's presentation to Hospital and diagnosis eight days later would, on the balance of probabilities, have allowed for earlier intervention and treatment options to have been made available and would have provided a better chance of a more favourable outcome.

Patient D (Essex Coroner) – Attendance of RPH witness required to explain the final part of the patient's pathway when transferred as an emergency for ECMO (RPH not an Interested Person (IP))

Background
Patient admitted to local hospital and treated for suspected acute myopericarditis. Discharged and had cardiac arrest at home, CPR, readmitted to local hospital in cardiogenic shock, respiratory failure with deep metabolic acidosis, referred to RPH ECMO service. ECMO team assessed patient and after discussion with the local team the decision was made to initiate renal replacement to optimise pH. Agreed patient a candidate for Veno Arterial (VA) ECMO, however would be challenging due to the calibre of their femoral vasculature (very small vessels). Patient

transferred same day to RPH for VA ECMO. Despite temporary circulatory support with peripheral veno-arterial extracorporeal membrane oxygenation (VA ECMO), patient continued to deteriorate with progressive multi organ failure and died.

Medical Cause of Death:
1a) Coronary artery vasculitis

Coroner's Conclusion:
Awaited

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