Regulation 28: Prevention of Future Deaths report

Neil HICKMAN (died 21.08.21)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Medical Officer** **East Kent Hospitals University NHS Foundation Trust** **Kent & Canterbury Hospital** **Ethelbert Road** **Canterbury** **Kent CT1 3NG**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 25 August 2021, one of my assistant coroners, Sarah Bourke, commenced an investigation into the death of Neil Hickman aged 63 years. The investigation concluded at the end of the inquest earlier today. I made a determination at inquest of death by natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Neil Hickman was treated at Kent and Canterbury Hospital (K&C) for myelodysplastic syndrome and then was referred to University College London Hospital (UCLH) for stem cell transplant. However, he died before the transplant could take place. His medical cause of death was:

	1a disseminated angio-invasive mycotic infection 1b immunosuppression 1c myelodysplasia
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. Mr Hickman was given frequent platelet transfusions at K&C, but his ferritin levels were not measured. When he was referred to UCLH, his ferritin level was found to be hugely raised. He was then treated with chelation therapy and ultimately his ferritin returned to a safe level, so this did not impact upon the outcome. However, it might for another patient. I think the reason that K&C does not measure the ferritin levels in such a situation is because K&C does not have funding for chelation therapy to treat iron overload. However, if iron overload is detected, then a referral centre such as UCLH can be called for advice, and the patient and their family can be informed so that they have the option of seeking private treatment.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 25 April 2022. 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 following.

	• [redacted], wife of Neil Hickman • University College London Hospitals NHS Trust • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 28.02.22 *ME Hassell*