Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 8868

Please reply to:
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Trust Management
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Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to sudden cardiac death (SCD) in patients with cardiac devices.

You asked: All questions are shown as received by the Trust.
Q1 How many patients pass through your morgue each year?
Q2 Approximately what proportion of these have a cardiac implantable device in situ? (PPM, ICD, ILR)
Q3 Does the hospital morgue also take deaths from the community, or is it for inpatients only?
Q4 Is there a cardiac physiology department on site at your hospital?
Q5 If a patient has a cardiac device in situ, is it routine practice for a device check to be undertaken after death?
Q6a If yes, is the information regarding rhythm/therapies at the time of death routinely added to the patient's notes/hospital record?
Q6b If yes, is the information regarding rhythm/therapies at the time of death routinely passed on to the clinical team?
Q7 If no and this is not routine practice, are there ever exceptions to this, i.e., occasions where a post-death device check is requested by the clinical team?
Q8 If yes, please elaborate (for example, how often or under what circumstances this occurs).

Trust response:
Q1.
2022=2,471 Admissions
2023=2,261 Admissions
Q2.

2022=59
2023=45
Q3. Both community and hospital patients are admitted
Q4. Yes
Q5. NO, it is not routine practice. The Cardiology Team would if asked to do so however.
For ICDs the Cardiology Team would always interrogate and deactivate and create a report stating the device has been deactivated
Q6a. If the Cardiology Team are asked to perform a check they would create a full report.
Q6b. They would have access to the report if one had been created.
Q7. Extremely rarely are the Cardiology Team asked to do this.
Q8. Once in the last four years.