REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Chief Executive - University College London Hospitals NHS Foundation Trust** **(2) Chief Executive - Radiology Reporting Online, London**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner North London
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** The investigation into the death of Georgina Violet SWINDELLS, aged 79, was commenced on 24 September 2013 and concluded at the end of the inquest on 7 February 2014. The conclusion of the inquest was narrative (Copy attached).
4	**CIRCUMSTANCES OF THE DEATH** Mrs Swindells underwent a right hemicolectomy at University College Hospital (UCH) on 16 September 2013 in order to treat colon cancer. Post-operatively she developed hypotension and was treated accordingly, including being administered a blood transfusion. The hypotension continued despite this treatment and concern remained regarding Mrs Swindells' condition. As such, she underwent a CT scan at 20.37hrs on 17 September. The scan was undertaken at UCH but, since it was performed 'out-of-hours', it was to be transferred to a reporting radiologist based at Radiology Reporting Online (RRO). This is an establishment which employs UK-registered radiologists based in the UK and Australia, who undertake out-of-hours reporting of urgent imaging for UCH. Failed attempts were made to transfer the scan images to RRO at 21.00, 21.30, 22.00 and 00.00hrs. From the evidence provided by UCH, it was not clear why the 'back-up' on-call interventional radiologist was not asked to attend the hospital in order to report the scan. Transfer was ultimately successful at 03.58hrs on 18 September. A verbal report was issued to the requesting clinicians at 04.20, which set out that there was ascites in the abdomen, which was suggested to be unusual 24 hours post-surgery. Bladder perforation was queried and a diagnostic aspiration of the fluid was undertaken. This demonstrated blood-stained fluid. A surgical review was requested and concern was raised regarding the possible urological injury. Over the next few hours, before urological review could occur, Mrs Swindells deteriorated. She died at 08.00hrs on 18 September 2013. A *post-mortem*

	reported attributed the cause of death to haemorrhage, related to the surgical procedure. A subsequent radiology report was undertaken at UCH at 11.39hrs; the radiologist was unaware that Mrs Swindells had died. The report concluded that 'This is not ascities… It is a large haematoma. She is clearly bleeding...'. This was confirmed by a subsequent *addendum* by a vascular radiologist. No incident reports were made at the time of Mrs Swindells' death. The investigation into the issue of the failed image transfer and apparently erroneous report were only undertaken in response to my request for statements from UCH and RRO. This investigation was unable to ascertain the cause for the image transfer failure. The data regarding the transfer would have only been available for 48 hours after the incident; it was not interrogated at the time. From the available evidence at the inquest it was not possible to conclude that the report delay and apparent erroneous report materially contributed to Mrs Swindells' death.
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. – (1) The cause of the image transfer delay has not been elucidated; I am concerned that a similar incident could recur as a consequence; (2) The lack of available data, required to investigate this issue, is also a cause for concern. This has not been addressed; (3) There is no image transfer backup process in place which could obviate against failure of the primary system; (4) The backup system in place (i.e. an on-call radiologist who can attend the hospital) appears not to have been implemented on this occasion. Again, the cause for this is unclear and I have concerns that the systems in place are not sufficiently robust; (5) The cause of the apparently erroneous scan report and steps taken to address this issue were not sufficiently clarified on the available evidence. This raises concerns that mis-reporting could happen again.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of the Trust and the Chief Executive of RRO, 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 9 April 2014. 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 Chief Coroner, Mrs Swindells' family and The Care Quality Commission.

	I am also under a duty to send the Chief Coroner a copy of your response. 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 by the Chief Coroner.
9	**12 February 2014** **Assistant Coroner R Brittain**