Walsall Healthcare NHS
NHS Trust

Our Ref:
Your Ref: Regulation 28 REPORT

Date: 14 January 2015

Patient Safety Department
Manor Hospital
Moat Road
Walsall
West Midlands
WS2 9PS

Mr Z Siddique
HM Coroner's Office
Crocketts Lane
Smethwick
B66 3BS

Tel:
Email:
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Dear Mr Siddique

Re: Tracey Bannister deceased
Date of Birth: 16th August 1984
Date of Death: 26th June 2014
Date of Inquest: 20th November 2014

I am writing in response to your report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. I fully accept that although the inquest verdict on Ms Bannister's death was natural causes, the circumstance of inadequate discharge information gives rise to the potential for an ongoing risk to future patients.

I would like to take the opportunity to assure you that as an organisation, we have formal processes for investigating serious incidents. We have taken this case seriously and have conducted a full review. To this end, a Root Cause Analysis was completed which included a review of the systems in place for maintaining safety at the time. The learning from both the Inquest and the internal investigation will be shared with staff across the organisation.

Summary of Incident

Ms Bannister underwent a repeat elective Endoscopic Retrograde Cholangio-Pancreatography (ERCP) on the 24 June 2014 to remove a stent. She consented to the procedure and the old stent was removed. There were some fragments of stone and debris found which came out with the stent removal. She was then transferred to the recovery area where her observations were checked. At 10:20 Pulse, BP, Respirations, O2 saturations, neurological status and pain level were all observed. Observations were re-checked every 15 minutes for the following 1hr and 30 mins. All observations were within acceptable parameters and Ms Bannister was subsequently discharged. A further follow up appointment was then made to deal with the management of any remnants of gall bladder and stones in two weeks' time.

At the time of the incident, the Endoscopy Unit used a discharge information leaflet which Ms Bannister was given. The leaflet explained if she continued to feel unwell or symptoms of pain worsened then she should contact her GP in the first instance.

When Ms Bannister arrived home she complained of feeling unwell and stayed in bed. On the morning of the 26 June she continued to feel unwell and then telephoned for an ambulance. She was taken to the Accident & Emergency department and arrived at 9.16am at Manor Hospital. On arrival she was very unwell and extremely jaundiced. Although alert on admission, she was peripherally cyanosed, had a low blood sugar and was pyrexial.

Shortly after arrival Ms Bannister went into cardiac arrest, however resuscitation was unsuccessful and she was pronounced deceased at 10.22hrs

Coroner's Concerns

During the course of the inquest the evidence revealed matters giving rise to concern. In the Coroner's opinion there is a risk that future deaths will occur unless action is taken.

The **MATTERS OF CONCERN** are as follows. –

There are well documented and recognised risks of ERCP surgery. These include:

1. Inflammation of the pancreas (pancreatitis) 2-4%
2. Infection in the bile duct (cholangitis). This is usually treated with antibiotics, but occasionally can be serious.
3. A hole may be made in the bowel (perforation) and if this happens surgery may be necessary.
4. Bleeding may result from the ECRP, which will usually stop quickly by itself. In severe cases, a blood transfusion or operation may be needed to control the bleeding.

The Coroners concern is that patients should be advised not only to contact their GP but also the department where surgery had been performed if symptoms of pain, raised temperature continue for more than 24 hours. In this case medical evidence suggested that had she attended Hospital twenty four hours earlier then the outcome may have been different.

Action Taken

A Root Cause Analysis was undertaken following Ms Bannister's death and action was taken with regard to record keeping and observation of patients. Additionally, a review of the discharge information leaflet was undertaken; however we fully acknowledge that the review did not adequately address the risks that have been identified during the inquest.

We have therefore revised the leaflet to include clear instruction to patients in line with the Coroner's recommendations. The leaflet has been approved by the Endoscopy Steering Group, shared with all staff and is now in use. The leaflet is enclosed.

Finally, may we take this opportunity to offer our unreserved apologies to Ms Bannister's family for the inadequate discharge information provided to Ms Bannister following the ERCP procedure, along with our sincere condolences for their loss.

Yours sincerely

Medical Director