REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Walsall Healthcare NHS Trust**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of Black Country.
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** On 30 June 2014, I commenced an investigation into the death of Tracey Bannister. The investigation concluded at the end of the inquest on 20 November 2014. The conclusion of the inquest was the deceased died on the 26 June 2014 from 1a. Sepsis due to 1b) Fulminant hepatic failure due to 1c) Biliary obstruction and 2) Obesity. I recorded a conclusion of Natural causes.
4	**CIRCUMSTANCES OF THE DEATH** 1. Tracey Bannister was a 29 year woman with a medical history of gall stones and right upper quadrant pain. 2. She had Endoscopic Retrograde Cholangio-Pancreatography surgery (ERCP procedure) on a number of occasions to remove the gall stones during 2013 and 2014. 3. She returned for repeat elective 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 and 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. 4. She was given a discharge leaflet which explained if she continued to feel unwell or symptoms of pain worsened then she should contact her GP in the first instance. 5. When she 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 A and E department and arrived at 9.16am at Manor Hospital. She appeared cyanosed with low blood pressure and BM 1.2mmol. 6. Blood gases revealed she was acidotic and she deteriorated and arrested. She suffered a cardiac arrest and was declared deceased at 10:22 hours.

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. – There are well documented and recognised risks of ERCP surgery. These include: • Inflammation of the pancreas (pancreatitis) 2-4% • Infection in the bile duct (cholangitis). This is usually treated with antibiotics, but occasionally can be serious. • A hole may be made in the bowel (perforation) and if this happens surgery may be necessary. • 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. My 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. Therefore, you may consider that the information and advice given to patients on discharge may need to be altered to take into account the lessons learnt from this inquest.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 15 January 2015. 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 and to the following Interested Persons and Ms Bannister's family. 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	**21 November 2014**