

## Helen Rachel Redman Senior Coroner for Central and South East Kent

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Kent and Medway Cancer Collaborative
1	CORONER
	I am Helen Rachel Redman, Senior Coroner for Central and South East Kent
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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a>
3	INVESTIGATION and INQUEST
	On 21/05/2014 I commenced an investigation into the death of Alice Ada Phyllis Dickenson, aged 78. The investigation concluded at the end of the inquest on 21 January 2016. The conclusion of the inquest was Mrs A A P Dickenson was referred to the Endoscopy Unit at William Harvey Hospital under the Rapid Access scheme for investigation of a 3 month history of weight loss and dysphagia. She wrote her relevant medical history of haemochromatosis on the patient questionnaire but the Nurse Endoscopist was not aware of this when he scoped her. He saw a lesion which he decided to biopsy, but which in fact was a gastric varix. This bled, and whilst treated, caused her death on 09.05.14. Mrs A A P Dickenson died at 1205hrs on 09.05.14 at William Harvey Hospital.
	Mrs A A P Dickinson died at 1205hrs on 9 <sup>th</sup> May 2014 at William Harvey Hospital.
	The cause of death was:-  1a) Gastrointestinal haemorrhage after biopsy procedure (hospital histology)  2 Cirrhosis of the liver, Haemochromatosis, Thrombocytopenia, Degenerative heart disease.
4	CIRCUMSTANCES OF THE DEATH
	Mrs Dickenson had a history of inter alia haemochromatosis. This was not mentioned on the brief GP referral form for the rapid access scheme. It was, however, mentioned by Mrs Dickenson on the patient questionnaire which she completed which was not transcribed onto the assessment form completed by the Nurse at the Endoscopy Unit. Therefore, the Nurse Endoscopist did not have sight of this important medical condition when viewing what he considered to be a lesion which he biopsied. The lesion was, in fact, a gastric varix which bled in spite of treatment to stem the bleeding. Mrs Dickenson died as a result of a gastrointestinal haemorrhage.
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: -
	That important past medical history may be omitted when referring the patient to the rapid access scheme for an endoscopy. The GP referral form is limited therefore enabling the omission of important medical conditions or history which would assist the endeoscopist.

6	ACTION SHOULD BE TAKEN
	In my opinion the GP referral form should be amended so that space is provided to enable the GP to complete all the relevant medical history for the endoscopist, or to confirm that there is no relevant medical history.
7	YOUR RESPONSE
	You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 March 2016. 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.
1	COPIES and PUBLICATION
	I am under a duty to send the Chief Coroner a copy of your response.
	I am 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.
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