REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Matthew Hopkins, Chief Executive, Barking, Havering & Redbridge University Hospitals NHS Trust. Executive Offices, Queens Hospital, Rom Valley Way, Romford, Essex, RM7 0AG.**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the Coroner area of East 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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 29th July 2016 an investigation was commenced into the death of Mrs Anna Teresa Walker, the investigation concluded at the end of the Inquest on the 8th March 2017. The conclusion at the Inquest was a narrative conclusion: *Mrs Anna Walker underwent a liver biopsy on the 8th July 2016. This was a necessary clinical procedure. She suffered a bleed as a result of a tear of the hepatic artery. This was likely to have been caused by the needle during the procedure. Serious bleeding complications are a rare, but recognised, complication of the liver biopsy procedure. Staff did not thereafter carry out the required post-operative checks on her. Had the appropriate checks been carried out, the bleed is likely to have been detected at an earlier stage and her death the following morning would have been avoided.*
4	**CIRCUMSTANCES OF THE DEATH** Mrs Anna Walker was in good health until around March 2016. At this time she was diagnosed to have a clot in her leg and was commenced on anti-coagulant treatment. In May 2016 she was referred to the fast-track referral cancer clinic by her GP. She underwent investigations which raised the suspicion of a pancreatic cancer with liver metastases. A liver biopsy was planned for the 8th July 2016. Due to being very unwell, she was admitted to hospital on the 6th July 2016. Her clinical condition improved with pain relief and intravenous fluids. She was considered to be fit for the liver biopsy on the 8th July 2016. She underwent the biopsy at around 10 am on the 8th July 2016. Post-operative checks were carried out at 10:45 and 11 am. The next check at 11:50 am noted a significant drop in blood pressure (69/38). The patient was noted to have fainted at that time. There was no record of her heart rate or oxygen saturation. She underwent a further ultrasound scan and no bleed was detected at that time. At around 2 pm she suffered a significant clinical deterioration and a further scan revealed a significant bleed. She underwent embolization of a tear to her hepatic artery. Her haemoglobin had reduced to 5.8. The embolization was successful. Despite care in ITU she did not recover and passed away in hospital at 11:30 am on the 9th July 2016. The post-mortem examination confirmed the cause of death was: 1a Intraperitoneal

	Haemorrhage 1b Tear of Hepatic Artery. This cause of death was agreed by the Consultant Radiologist who performed the procedure.
5	**CORONER'S CONCERNS** **During the course of the Inquest evidence gave rise to the following matters of concerns:-** 1. The Consultant Radiologist who performed the procedure confirmed that the post-operative checks were not compliant with the Trust's Protocol. Only 2 complete checks were carried out (at 10:45 and 11 am). The check at 11:50 was not complete. There were no further post-operative checks documented on the observation sheet after 11:50, despite the concerning observations at that time. The Consultant Radiologist gave evidence that had the appropriate post-operative checks been carried out, the bleed was likely to have been detected at an earlier stage. He further confirmed that had the bleed been detected at an earlier stage Mrs Walker's death is likely to have been avoided on the 9th July 2016. 2. The Consultant Radiologist confirmed that in his opinion, the reasons for the failure to carry out the required observations were: I. The failure of the porters to collect the patient. He stated that the failure of the porters to attend, was reported as a serious incident. He stated that this issue has still not been resolved and is an ongoing issue within the Trust. II. The failure of nurses on the ward to take her back. (Albeit the evidence revealed that the nurses on the ward were concerned about her low blood pressure). III. The Consultant described a "chaotic situation" with patients coming in for treatment to the radiology department but patients not going up to the ward. IV. He stated that Mrs Walker was not in the appropriate environment for post-operative monitoring. 3. The lines of clinical accountability post-procedure, was unclear. The radiologist confirmed that Mrs Walker was no longer the responsibility of the radiology team after the procedure, as she should have gone up to the ward. The ward however were concerned with her clinical parameters and considered that she should remain with the radiologist. 4. [redacted] (husband) provided guidance from the BMJ setting out the suggested post-biopsy observations. This included observations every 15 minutes for the first 2 hours and then every 30 minutes for 2 hours thereafter. I would respectfully request that the Trust consider the Policy that it has in place, in light of the BMJ recommendations. 5. 2 incident report forms were completed in relation to Mrs Walker's death. (Form number 52695 and Form number 53952). The outcome of the main incident report form (52695) concluded that *appropriate care was given and this was not considered a Serious Incident*. This conclusion was at odds with the evidence heard from the Trust's Consultant Radiologist. It was also at odds with the Trust's Protocol for post-operative monitoring and the recorded post-operative observations.
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 **4th May 2017**. 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, to the Care Quality Commission, to [redacted] and to the Director of Public Health Mr Matthew Cole. 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	**[DATE]** 15.3.17 **[SIGNED BY CORONER]**