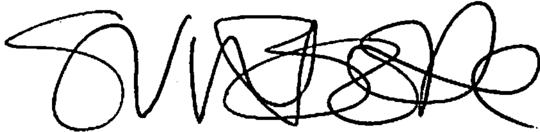
Coroner ME Hassell
HM Senior Coroner
Inner North London

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Simon Harrod** **Clinical Director** **Bart's Health NHS Trust** **Ground Floor,** **Pathology and Pharmacy Building,** **The Royal London Hospital,** **80 Newark Street,** **London,** **E1 2ES**
1	**CORONER** I am Sarah Bourke, assistant coroner, for the coroner area of 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** On 18 July 2017 I commenced an investigation into the death of Angela Sandra Ivina West (age 57). The investigation concluded at the end of the inquest on 12 June 2018. The conclusion of the inquest was a narrative conclusion which is set out in the section below. The medical cause of Ms West's death was 1a: acute cardiac arrhythmia 1b: hyperkalaemia and hypovolemia 1c: end stage kidney disease 1d: lithium therapy for bipolar disorder 2: cholecystectomy
4	**CIRCUMSTANCES OF THE DEATH** Angela West had end stage kidney disease, which required dialysis. She underwent surgery to remove her gall bladder at the Royal London Hospital on 6 July 2017. She initially recovered as expected. During 7 July, she became drowsy and had a slightly

	increased heart rate of 105 bpm. During 8 July, her heart rate increased over the course of the day. She also had increased inflammatory markers and reduced oxygen saturations. Her NEWS score increased from 2 to 5 over the course of the day. The possibility of a bile leak was raised and following a CT scan on the evening of 8 July, a decision was made to undertake a laparoscopy the following day. Once the possibility of a bile leak was identified, other potential reasons for her deterioration were not explored. It was decided that Ms West would have dialysis prior to undergoing laparoscopy because her potassium level was raised at 6.2. Ms West was not referred to the Critical Care Outreach Team until the morning of 9 July. In addition, she was not escalated to Consultants until the afternoon of 9 July. She remained tachycardic. She underwent dialysis during the afternoon. At the end of dialysis, her potassium levels were 4.1, lactates were 5.1 and her heartrate was 140 bpm, which was suggestive of hypovolemia. Ms West returned to her surgical wars around 6 pm. Whilst being assessed by the anaesthetist prior to surgery, she was found to have a respiratory rate of 40 breaths per minute and be tachycardic, confused and peripherally shut down. A venous blood gas showed that she had marked acidosis. Her potassium level was 6.1 and lactate was 10. Ms West went into cardiac arrest whilst being positioned for a chest x-ray. It was not possible to resuscitate her. Her death was confirmed shortly after 8 pm.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) Ms West was identified as being at increased risk of surgical complication given her underlying kidney disease. Ms West's surgery was listed for a Thursday. The effect of this was that much of her care in the period following her deterioration was dealt with under weekend staffing arrangements. (2) Ms West was located on a general surgical ward. (3) The investigation highlighted issues relating to Ms West becoming dehydrated. Neither myself nor the clinical investigators were able to locate any fluid balance charts for Ms West.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 23 August 2018. 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. • [redacted] (Ms West's daughter)

	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	 **Sarah Bourke** **Assistant Coroner** **27 June 2018**