Re : MARIAN HOSKINS DECEASED

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Clinical Director, Medical Director and Director of Quality and Safety at Barts Health NHS Trust**
1	**CORONER** I am Alison Hewitt, HM Senior Coroner for the City of 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** I commenced an investigation into the death of Marian Hoskins. The investigation concluded at the end of the inquest on 22 November 2018. My conclusion as to the death was that the Deceased : "Died as a result of a recognised complication of an investigative medical intervention."

4	**CIRCUMSTANCES OF THE DEATH** In October 2016 the Deceased was admitted to St Bartholomew's Hospital having suffered an acute non-ST elevation myocardial infarction and she was treated by percutaneous stenting of the right coronary artery. Moderate to severe stenosis in the left anterior descending artery was noted and a plan was made for investigative pressure wire testing in order to assess the functional impact of the stenosis and whether stenting of the area was indicated. The evidence suggested that there was insufficient discussion with the Deceased to enable her to consider properly alternative non-invasive investigations but it was not possible to know whether sufficient discussion would have resulted in a different plan. On the 14th December 2016 the Deceased underwent electively pressure wire testing in the course of which there was iatrogenic dissection of the artery. This was quickly treated by stenting but the consequential impairment of blood flow to the distal artery caused the Deceased to suffer damage to the heart tissue and another heart attack. Further, the placement of the stent resulted in the loss of septal branches. As a result, over the following days the Deceased developed a ventricular septal defect. Investigative imaging suggested that percutaneous intervention could be used successfully to repair the defect and this was attempted on the 28th December 2016. However, it was not successful because of the extent of the damage which had in fact been caused by the infarction, and surgical repair was therefore attempted later the same day. Post-operative testing showed a small residual defect but further surgical treatment could not safely be undertaken. The Deceased was given maximal support but, after a period of stability, her condition deteriorated. An attempt to repair the residual defect percutaneously was made on the 10th January 2017 and was anatomically successful but on the 11th January 2017 the Deceased suffered multi-organ failure and she died.
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 as a

result unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTER OF CONCERN** is as follows :
As stated above, at the Inquest I found that in October 2016 the Deceased was admitted to St Bartholomew's Hospital having suffered an acute non-ST elevation myocardial infarction and she was treated by percutaneous stenting of the right coronary artery. Moderate to severe stenosis in the left anterior descending artery was noted and a plan was made for investigative pressure wire testing in order to assess the functional impact of the stenosis and whether stenting of the area was indicated. The evidence suggested that there was insufficient discussion with the Deceased to enable her to consider properly alternative non-invasive investigations (although it was not possible to know whether sufficient discussion would have resulted in a different plan, not least because it was clear from the evidence that the clinical advice to the Deceased was and would have been that the invasive pressure wire testing was preferable to the non-invasive alternatives).
From the evidence I heard it was apparent that the insufficient discussion with Mrs Hoskins about the investigatory options resulted, in large part at least, from the absence of a clear system and process designed to ensure that full and informed consent is obtained. In particular, the advice and decision making about the pressure wire testing was made (in principle at least) at about the time of her initial percutaneous stenting in October 2016 and without sufficient subsequent out-patient access to advice and discussion.
Prior to the conclusion of the Inquest I received a statement dated 21 November 2018 from [redacted], Director of Quality and Safety.

	[redacted] stated that the Trust has started a "major quality improvement project" to improve the process of gaining informed consent and he set out details of steps which have already been taken and those planned. In paragraph 10 of the statement it is noted that informed consent is a process that is undertaken over time and that the Trust's current process does not include informed consent being obtained prior to the patient being admitted for a specific procedure. I am concerned that the insufficiency of the process in the Deceased's case resulted largely from the absence /insufficiency of outpatient contact to enable full communication from the clinicians to the patient and family and vice versa, and that this situation persists. Although [redacted] statement indicates that the Trust "will work towards" informed consent being undertaken as an outpatient, the current absence of a system to facilitate informed consent being taken and to ensure it is obtained prior to the patient's admission for the procedure in question, is of concern in relation to the prevention of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing the concerns set out above 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 **6th March 2019**. 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 following Interested Persons and to the other organisations listed below which may find it useful or of interest. [redacted] 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	**Alison Hewitt** **HM Senior Coroner** **9th January 2019**