REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

This report is being sent to the Chief Executive for Ashford and St Peter's Hospitals NHS Foundation Trust

CORONER

Jessica Russell-Mitra, Assistant Coroner for Surrey

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/part7/made

INVESTIGATION AND INQUEST

On 27th June 2017, Mr Simon Wickens, Area Coroner for Surrey opened an Inquest into the death of Mrs Alice Doris Dixon, who died at St Peter's Hospital, Surrey on 17th June 2017, aged 83 years old. The investigation concluded at the end of the Inquest on 28th November 2018.

CIRCUMSTANCES OF DEATH

At the end of the Inquest I recorded the following narrative:

On 10th June 2017 Alice Doris Dixon attended St Peter's Hospital A&E on referral from her general practitioner due to increasing anaemia and shortness of breath. As part of the investigation of her condition, a CT scan was requested. Alice was kept on the ward overnight and at about 10.35am on 11th June 2017 she attended the radiology department accompanied by her daughter. She was taken into the radiology scanning room without her daughter and asked questions for a consent form which was not signed by her or anyone on her behalf and was not signed by the radiographer. Some details of her previous scans and her renal funcrion were checked. Her hearing and cognisance were not checked in detail nor

was her fitness or her ability to lie flat. Alice was noticeably wheezing before the scan commenced. The CT scan was started and it took about 3-4 minutes in total. During the course of the scan contrast dye was injected via a pre-placed cannula. Alice suffered an anaphlyactic shock including severe bronchospasm. She was found after the scan by the radiographer to be unresponsive and she became cyanotic. Resuscitation commenced and ROSC was established. Alice was admitted to ITU in grave condition and deteriorated: no further intervention was considered possible. She was transferred to Holly Ward where she was treated palliatively and died as a result of the consequences of the anaphylactic shock.

MEDICAL CAUSE OF DEATH

The medical cause of death was:-

1a cardio-respiratory failure

1b Cardio-respiratory arrest

1c Anaphylactic shock secondary to Computed tomography contrast media on a background of anaemia of uncertain aetiology.

2 General frailty atrial fibrillation colitis and gastritis

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:

1. The evidence before the court suggested that Mrs Dixon was not accompanied or escorted by a medical professional to the radiography suite.
2. Her daughter was not invited into the room when the pre-scan form was completed.
3. The consent form was filled in by the radiographer on asking questions of Mrs Dixon alone who was vulnerable, unwell, confused and hard of hearing in an unfamiliar environment without assistance.

4. The consent form was also supplemented with information from the computer records but it was not clear on the form or in evidence which information came from Mrs Dixon and which from records.
5. Part of the consent form was filled in and initialled by a person who cannot be identified by the Trust as to which member of staff it was.
6. Part of the consent form about previous contrast was left blank and although the RCA had the information before the scan it was not noted.
7. The radiographer who filled in the form had no training in communication or language difficulties and there were no other resources to aid communication and the questions were yes/no.
8. No notes were made in the radiography suite.
9. Mrs Dixon was assessed before attending the radiography suite but there was no one with clinical skills to assess her prior to the scan itself and .
10. There was no note to assist the radiographer with any vulnerabilities Mrs Dixon had (including crucially hearing and understanding difficulties and that she was not able to lie flat)
11. The way the room was set up it was difficult for the radiographer to realise that Mrs Dixon was having breathing difficulties during the scan as he was only able to see the top of her head and it was hard for him to hear over the sound of the scanner through the intercom in the scanner itself.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of this report, namely by 3rd July 2019. I may extend the period.

Your response must contain details of action taken or proposed to be taken and a timetable for action. Otherwise, please provide explanation why no action is taken.

COPIES AND PUBLICATIONS

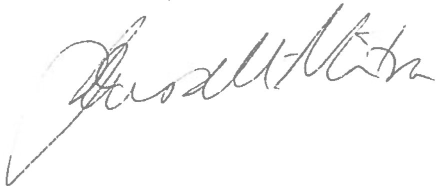
I have sent a copy of my report to the Chief Coroner and to Mrs Dixon's family. I have also sent a copy to

I have sent a copy of my report to Surrey County Council who may find it useful or of interest.

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 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.

Dated: 5th April 2019



Signature:

Jessica Russell-Mitra, HM Assistant Coroner Surrey