Regulation 28: Prevention of Future Deaths report

Keith HILL (died 27.06.19)

	THIS REPORT IS BEING SENT TO: **1. Dr Alistair Chesser** **Chief Medical Officer** **Barts Health** **Royal London Hospital** **Whitechapel Road** **London E1 1BB**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 3 July 2019, one of my assistant coroners, Sarah Bourke, commenced an investigation into the death of Keith Hill aged 71 years. The investigation concluded at the end of the inquest yesterday. I made a determination at inquest that Keith Hill died from a combination of natural causes and the complications of medical treatment. I recorded a medical cause of death of: 1a general sepsis 1b obstructive ischaemic biliary stricture 2 ischaemic heart disease, diabetes and renal failure.

4	**CIRCUMSTANCES OF THE DEATH** Mr Hill was admitted to the liver unit of the Royal London Hospital with a working diagnosis of biliary sepsis. He had heart disease, diabetes and kidney failure. On 7 May 2019, he underwent endoscopic retrograde cholangio-pancreatography (an ERCP). However, he remained very unwell. His renal impairment deteriorated and he was put on haemodialysis. The cause of the ongoing inflammation of his liver was unclear. He was known to be at high risk for a liver biopsy, but it was considered there was no alternative to this. A transjugular biopsy was planned by the hepatologists because Mr Hill had ascites, but the interventional radiologist conducting this decided upon a percutaneous approach despite its higher risk of bleeding, because improvement in the ascites made this feasible. The percutaneous approach is more likely to yield a successful sample. The biopsy was carried out on 24 May, but within a few hours Mr Hill had developed a bleed from the biopsy site, and later that same day he had to undergo a laparotomy to oversew the hole. He later suffered bowel haemorrhage and was treated repeatedly for this. Meanwhile, the biopsy had revealed intra hepatic biliary obstruction. On 24 June, the microbiologists advised the antifungal agent micafungin. The hepatologists considered this but were concerned it was too hepatotoxic. In the event, Mr Hill deteriorated and on 25 June a prescription for micafungin was written. However, the prescription was never filled. Mr Hill died on 27 June 2019. After his death, the results of his blood cultures demonstrated that he did not have fungal sepsis, so the failure to administer the micafungin had no impact in this instance. Of course that might not be the case for another patient.
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.

	1. When the plan changed and the transjugular liver biopsy became a percutaneous one, there was no communication between the interventional radiologist and the hepatologists. Even if it had not changed the plan, Mr Hill's management would have benefited from a robust discussion between the specialists in these two fields, and an accurate record of the decision making. 2. Mr Hill's medical records were at times inadequate. The microbiologists thought that the junior hepatologists were making a record and vice versa. In the event, neither did. Most specifically, following the repeated advice of the microbiologists, the decision to change the plan and to prescribe micafungin on 25 June was not documented, it was simply written up on the prescription chart. 3. The junior pharmacist charged with dispensing the micafungin on the evening of 25 June recognised its toxicity to the liver and could not see from the medical record that Mr Hill's liver function tests and hepatitis had been taken into account in the prescription. The last relevant entry in the medical record indicated that the micafungin should be held off. He sought senior guidance. However, there was no specialist hepatology pharmacist on the list of available contacts. Recognising he was outside his expertise, he contacted an intensive care specialist pharmacist, the on call microbiologist and the medical doctor looking after Mr Hill. However, no decision was made regarding the micafungin and so it was simply not given. A professor of hepatology was on call and knew Mr Hill's situation well, but he was not contacted by the ward doctor (or by the microbiologist or a senior pharmacist). Despite improvements to the availability of senior pharmacists on call at the Royal London Hospital, concern remains about night time care and proper scrutiny of prescriptions. Junior medical staff do not appear to be sufficiently supported in this.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 24 February 2020. 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • [redacted], partner of Keith Hill • Professor [redacted]r, consultant hepatologist 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 20.12.19