REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Black Country Pathology Services c/o New Cross Hospital** **2. Medical Director, Walsall Manor Hospital**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 20 May 2019, I commenced an investigation into the death of Ms Jennifer McKoy. The investigation concluded at the end of the inquest on 19 February 2020. The conclusion of the inquest was a short narrative conclusion of: Jennifer McKoy died after developing a recognised complication of Pulmonary embolism after a delayed diagnosis of adenocarcinoma of the gallbladder. The cause of death was: 1a Pulmonary Venous Thrombo-embolism 1b Deep Phlebo-Thrombosis 1c Disseminated Adenocarcinoma of Gallbladder(operated)
4	**CIRCUMSTANCES OF THE DEATH** i) The deceased was a 58-year-old female patient who initially attended Walsall Manor Hospital for a laparoscopic cholecystectomy on 14 August 2018. Prior to this she was referred by her GP in March 2018 for pain in her right side. A subsequent ultrasound at hospital confirmed she had a thick-walled gall bladder with multiple gall stones. ii) The surgical procedure was described as difficult due to a very thick-walled gallbladder packed full of stones and she was discharged home the following day. The gall bladder was sent for histology and reported to show 'chronic cholecystitis'. iii) She re-attended the emergency department at Manor Hospital on 14 February 2019 with pain and a growing mass at the port site, this was reviewed and felt to be a haematoma or scar tissue and the patient was discharged home with plans for follow up. iv) She was then seen in the vascular clinic on 20 March 2019 and ultrasound completed of mass at port site which was suggestive of haematoma. A further MRI completed on 15 March 2019 identified adenocarcinoma of

	gallbladder bed, abdominal wall, multiple hepatic and peritoneal and bony metastases with some ascites. v) A retrospective review of the histology from 2018 showed that these slides demonstrated a carcinoma at that time which had not been identified. vi) The patient was referred to oncology for palliative chemotherapy and sadly died on 17 May 2019.
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. Evidence emerged during the inquest that there was an inadequate audit process in place for monitoring non-suspicious samples by way of dip-sampling. 2. There was limited evidence of any protocol or policy in place for managing the anticoagulation/prophylaxis regime for community patients who have identifiable risk factors for developing complications.
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. 1. In consultation with the Black Country Hospital Trusts the Black Country Pathology services may wish to review their audit/dip-sampling processes for both suspicious and non-suspicious samples. 2. The Hospital Trust may wish to consider reviewing their policy on anticoagulation/prophylaxis for community patients.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6 May 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 Chief Coroner and to the following Interested Persons; Family. 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	**11 March 2019** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**