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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. EMIS [Egton Medical Information Systems] |
| 1 | **CORONER**<br><br>I am Miss Alison McCormick, Assistant Coroner for the coroner area of Berkshire. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 11th November 2021 I commenced an investigation into the death of Hugo Carlos (age 30 years). The investigation concluded at the end of an inquest on 12th January 2023. The conclusion of the inquests into the death was:<br><br>Mr Carlos died from liver infarction and liver failure following an interventional radiology procedure to embolize bleeding from a fistula between the hepatic artery and bile duct. This was a recognised risk of a potentially life-saving and necessary medical procedure. The fistula developed following an interventional radiology procedure to insert a biliary drain into the bile duct. Bleeding following biliary drain insertion was a known risk of this medical procedure. The biliary drain was necessary to treat obstructive jaundice which was caused by a hepatocellular adenoma, which grew and obstructed the bile duct, causing Mr Carlos to experience symptoms of obstructive jaundice in late August 2021. The hepatocellular adenoma was first seen as an incidental finding on an ultra sound scan in March 2019. The hepatocellular adenoma was diagnosed as a focal nodular hyperplasia on MRI scan with contrast reported in June 2019. From a liver biopsy taken on 26th October 2021 and on Post Mortem the liver lesion was diagnosed not as a focal nodular hyperplasia, but as a hepatocellular adenoma. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The Deceased, Hugo Carlos, date of birth 22 May 1991, was 30 years old at the time of his death in November 2021.<br><br>In March 2019 the Deceased had a check-up at a private hospital. An abdominal ultrasound scan showed a large vascular lesion in the liver.<br><br>On 26 March 2019, the Deceased attended his general practice to discuss the scan result and an MRI scan was recommended.<br><br>The MRI scan was undertaken on 29th May 2019.<br><br>At a follow up GP appointment on 10th June 2019 it was advised that if the patient remained asymptomatic there should be an ultrasound scan in 1 year.<br><br>The Deceased contacted the surgery and requested follow up scans in April 2020 and July 2021. Follow-up scans were arranged through the GP.<br><br>In September 2021 an ultrasound scan showed that the liver lesion had increased in size and there was mild intrahepatic biliary dilatation. |

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| | The Deceased was subsequently admitted to hospital on 12 October 2021 and sadly passed away on 8 November 2021.<br><br>A post-mortem confirmed that the cause of death was due to acute liver failure and liver infarction following embolization of the hepatic artery to arrest severe haemorrhage as a consequence of a percutaneous biliary drain insertion for the management of obstructive jaundice secondary to a large hepatocellular adenoma. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the investigation my inquiries 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:<br><br>A partner in the Deceased's general practice gave evidence to the Inquest that the practice uses the EMIS system, and that, unlike SystmOne, the system does not have a scheduled task feature which would allow the GP to create an alert on a patient's record to flag up when a task is due at a future date – eg an alert to book a follow up scan in one year.<br><br>I have been informed that EMIS does allow a future entry into a patient's record (a diary date), but this must be for a specific clinical code and the only way to see that there is a due diary date entry is to access the patient's record and view the summary page or diary section. Unless the GP has reason to inspect the patient's clinical record and examine the summary or diary pages there is no way of being alerted that a new task needs to be completed for that patient. Further, it is not possible to add a pop-up-linked diary date entry for a specific task (such as a scan) outside the EMIS determined list.<br><br>This creates a situation where the responsibility for ensuring that follow up investigations are undertaken at the correct time is placed onto the patient, and the patient will have to contact the GP to request follow-up.<br><br>In this case the Deceased was diligent in contacting his GP surgery to request repeat scans, but I consider that unless some action is taken there is a continuing risk of patients not contacting the GP to make a request for follow-up and therefore becoming lost to necessary follow-up. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th March 2023. 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 |

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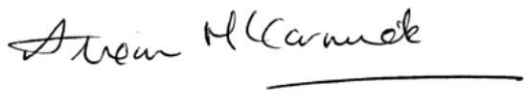
| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>• The family of Hugo Carlos<br>• Royal Berkshire NHS Foundation Trust<br>• Strawberry Hill Medical Centre<br><br>I am also under a duty to send the Chief Coroner 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 | **1st February 2023**<br><br>  <br><br>Alison McCormick<br><br>Assistant Coroner for Berkshire |