MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON CORONERS SERVICE
Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted], **Chief Executive Officer, Barts Health NHS Foundation Trust, Royal London Hospital, Whitechapel Road, Whitechapel, London, E1 1BB**
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 26th July 2021 I commenced an investigation into the death of Raquel Mellonie Harper, aged 33 years. The investigation concluded at the end of the inquest on 2nd May 2023. The conclusion of the inquest was a narrative conclusion: *Raquel Harper died as a result of natural causes. Her death was however contributed to by an omission of hospital staff to carry out appropriate investigations and to instigate timely treatment for her pulmonary embolism.*
4	**CIRCUMSTANCES OF THE DEATH** Raquel Harper attended Whipps Cross Hospital on the 23 June 2021. She complained of a 5-day history of shortness of breath and difficulty breathing. Raquel had

	a low oxygen saturation, a high respiratory rate and a tachycardia. The assessing doctor used the pulmonary embolism rule out criteria (PERC), to rule out the likelihood of a pulmonary embolism causing her symptoms. The PERC test was positive, and a D Dimer should have been carried out. This was not done. A diagnosis of iron deficiency anaemia was made, based upon a low haemoglobin and low MCV level. Raquel was admitted to hospital and suffered from periods of desaturation requiring medical review and assessment. The diagnosis of iron deficiency anaemia was not re-visited and further investigations, such as arterial blood gases were not carried out. In the very early hours of 25 June 2021, Raquel became critically unwell. She required escalation of her care, but this was not provided until she was in a peri-arrest state at around 0330 on 25 June 2021. Raquel suffered a cardiac arrest at around 0400 and received resuscitation and thrombolysis. Sadly, there was no response to the emergency efforts and Raquel passed away at Whipps Cross Hospital on 25 June 2021. Had Raquel received the D Dimer test on the 23 June 2021, in accordance with the Trust's policy, this is likely to have triggered further investigations which would have resulted in a diagnosis of pulmonary embolism and a treatment dose of lower molecular weight heparin. On the balance of probabilities this would have prevented Raquel's death on the 25 June 2021.
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 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: 1. There was a lack of thorough history taking and a number of assumptions were made on the basis of Raquel's high BMI. There was an assumed chronic low oxygen saturation with no evidence that the doctors had checked the records available or asked the patient about her baseline. The oxygen saturations recorded in the Barts sleep apnoea clinic in 2015 and 2016 were noted to be 99% and 100%. 2. There was a lack of escalation of monitoring following the NEWS score of 10. It is of concern that the NEWS policy was not complied with by the nursing staff. 3. There was disagreement between senior clinicians as to how the Trust's PE policy should have been applied. The policy is often not used in accordance with the specific wording. For example, the requirement for pleuritic chest pain is often ignored in practice. A senior clinician within the Trust considered that the caveat for pleuritic chest pain in the policy should be reviewed. In addition, the senior clinician described some of the wording in the policy as "clumsy". In light of this, the Trust may wish to review the policy.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 **7 August 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested

	Persons the family of Ms Harper, CQC and to the local Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**13 June 2023**