MR G IRVINE
SENIOR CORONER
EAST LONDON
East London Coroner's Court, 124 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:** **1. [redacted], Chief Executive Officer, Barts Health NHS Foundation Trust** [redacted] **2. [redacted], National Medical Director, NHS England** [redacted] **3. Rt Hon Steve Barclay MP, Secretary of State for Health & Social Care** [redacted]
1	**CORONER** I am Graeme Irvine, senior 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 22nd June 2022 this Court commenced an investigation into the death of Christine Nakafeero, age 56 years. The investigation concluded at the end of the inquest between 20th and 21st July 2023. The court returned a narrative conclusion. *"Christine Goodfriday Nakafeero died at home on 21st June 2022 due to a pulmonary embolism caused by a deep vein thrombosis ("DVT"). The DVT was made more likely by: a medical condition, uterine fibroids and the treatment for that condition, tranexamic acid.*

	In 2019 Ms Nakafeero was referred to the gynaecology clinic with a recommendation that she underwent a hysterectomy to effectively treat her uterine fibroids. Due to a breakdown of communication between Ms Nakafeero and the Trust, the surgery was not undertaken. Had the surgery taken place, Ms Nakafeero would probably not have developed a pulmonary embolism in June 2022." Ms Nakafeero's medical cause of death was determined as: 1a Pulmonary Emboli; 1b Deep Vein Thrombosis; II Uterine Fibroids
4	**CIRCUMSTANCES OF THE DEATH** Christine Goodfriday Nakafeero was found unresponsive at home on the evening of 21st June 2022. Despite the best efforts of her family and emergency services she was declared deceased that evening. Her death was caused by a pulmonary embolism, in turn caused by a deep vein thrombosis. Earlier that day Ms Nakafeero had been discharged from hospital having presented with symptoms of menorrhagia and associated pain and anaemia on 19th June 2022. Whilst an inpatient, Ms Nakafeero was assessed for risk of venous-thrombo-embolism ("VTE") risk utilising the Trust's VTE policy, she was categorised as having zero risk of thrombo-embolism. Ms Nakafeero had been diagnosed with uterine fibroids since 2019 and had been prescribed tranexamic acid and pain relief to control the symptoms.
5	**<u>CORONER'S CONCERNS</u>** 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. Ms Nakafeero was assessed at a Gynae-oncology clinic in early 2019. The patient was diagnosed as not suffering from any form of cancer and was therefore referred on to the "benign" gynaecology team. Ms Nakafeero was advised that it was likely that the most effective treatment for her condition was a hysterectomy. It was expected that the likely wait for this treatment would be 6 months. Ms Nakafeero was not allocated an appointment and therefore had not received the necessary surgery by the time of her death in June 2022. Had the surgery been undertaken it is probable that she would not have developed a pulmonary embolism. Although the trust has investigated these circumstances and implemented change, no clear explanation could be offered for why the deceased slipped out of this care pathway. I am not satisfied that the risk of re-occurrence has been properly addressed. 2. The clinicians treating Ms Nakafeero assessed her VTE risk utilising an established algorithm based on national guidance. The assessment was undertaken appropriately but it failed to identify two risk factors which made the

	formation of a DVT more likely, namely, large uterine fibroids and the use of tranexamic acid. I have concerns that the omission of these factors in the assessment criteria limited the effectiveness of the risk assessment.
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 **Monday 18th September 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 Nakafeero. I have also sent it 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	**24/07/2023**