Re : PETER JOHN HARRIS DECEASED

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Radiology Clinical Lead and the Clinical Governance Lead for the Barking, Havering and Redbridge University Hospitals NHS Trust.**
1	**CORONER** I am Alison Hewitt, HM Senior Coroner for the City of London.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** I commenced an investigation into the death of Peter John Harris, aged 73 years, who died at St. Bartholomew's Hospital, London on the 10th June 2022. The investigation concluded at the end of the inquest on the 11th July 2023. The conclusion of the inquest was that the medical cause of death was – Ia Multi-Organ Failure Ib Recurrent Global Pericardial effusion Ic Metastatic lung adenocarcinoma T4 N2 M1a II Carcinoma Prostate and my conclusion as to the death was – Natural Causes.

4	**CIRCUMSTANCES OF THE DEATH** My findings as to the circumstances of the death, as recorded on the Record of Inquest, were as follows: 1. On the 11th May 2022 Peter Harris was admitted to Queens Hospital, Romford and was found to have a large pericardial effusion and a diagnosis of stage 4 metastatic lung cancer was made. The condition was untreatable but palliative chemotherapy was planned. However, on the 27th May 2022 and the 3rd June 2022, the Deceased was re-admitted with non-resolving pneumonia which was treated with anti-biotics. His symptoms worsened and he was found to have a recurrent pericardial effusion and, on the 5th June 2022, he was transferred to St. Bartholomew's Hospital, London for a "pericardial window" to be performed. However, before going to theatre, the Deceased suffered a cardiac arrest. He was resuscitated and intubated, and he underwent an emergency pericardiocentesis before transfer to the Intensive Treatment Unit. Despite support, attempts to wean the Deceased from sedation were unsuccessful, and he developed multi-organ failure and died at 17.30 hours on the 10th June 2022. 2. In 2020, whilst being investigated by the colorectal service at Queens Hospital, a CT scan performed in November 2020 raised the possibility of a malignant process in the lung but this report was not seen by the clinical team. If it had been seen, it is likely that annual review and monitoring would have been arranged and this may have enabled the lung tumour which subsequently developed to have been diagnosed and treated before it reached stage 4. There was, therefore, a lost opportunity to monitor for and, possibly, to diagnose and treat, the lung cancer. However, it is possible that the tumour, which probably developed quickly, would not have been found even by annual review. Consequently, on the evidence, it is not possible to ascertain whether monitoring probably would, or would not, have prevented the Deceased's death.

5	**CORONER'S CONCERNS** Background: 1. The evidence at the inquest showed that the results of two separate scans performed on the Deceased, both of which had concerning outcomes, were not seen and acted upon in a timely manner. 2. First, on the 8th October 2020, a Consultant Colorectal Surgeon at Queens Hospital requested a CT scan of the Deceased's thorax, abdomen and pelvis because the Deceased had reported significant weight loss and other symptoms. The radiologist's report on the scan, dated the 8th November 2020, mentioned findings of multiple lung nodules and included a differential diagnosis of lung metastases. This outcome was never seen by the requesting clinician, nor any other clinician (including the Deceased's General Practitioner). I was told that the radiologist's report was not escalated or alerted to the clinical or multi-disciplinary teams because the requesting form had indicated that the scan was to rule out malignancy; I was told that "the reporter would not raise this as an incidental finding because malignancy was already queried and would expect the referring clinician to review results". The Consultant Colorectal Surgeon told me, however, that his understanding of the system was that he would be alerted to any finding or suspicion of malignancy. Further, although the Deceased had subsequently been given three outpatients appointments, the error was not picked up through these because all three appointments were cancelled by the hospital and the Deceased was not seen by the colorectal team again. 3. Secondly, a further CT scan of the Deceased's thorax was undertaken on the 9th April 2022, but the formal report (suspicious for lung cancer) was not made until the 24th May 2022, and this resulting in delay in the Deceased being seen on the cancer pathway by the respiratory team. It

seems that the delay in reporting was because a second hospital number had been used for the Deceased when the scan was performed in an external CT scanner located on the King George Hospital site.

4. At the inquest, I heard oral evidence from [redacted], and I received documentary evidence, explaining the changes which have been made since the Deceased's death. The documentation received included an 11 point Action Plan, supported by evidence as to the action that has been taken. On the basis of that evidence, I am satisfied that most of the concerns relating to the Deceased's scan reporting and other management have been addressed.

5. I do, however, have two ongoing concerns about the system in place for the communication of concerning radiological findings. Steps have been taken to improve the system previously in place. In particular, I have been provided with a copy of the Trust's new "Radiology Unsuspected Cancers and Critical Findings Protocol" which, I am told, has now been approved, and will be adopted, by the Radiology Clinical Leads and Clinical Governance Leads across North East London. I was also told that a new electronic scan requesting and reporting system will "go live" in August 2023, and that this will enable unexpected cancers and other incidental critical findings to be "red-flagged" directly to the requesting team. The system will also have an "acknowledgment option" enabling the referring doctor to click on a read receipt for all radiology reports.

The MATTERS OF CONCERNS are as follows:

Concern 1:
The Trust's new policy is concerned with ensuring that <u>unexpected</u> cancer or other critical radiological findings are highlighted to the requesting team. However, the evidence at the inquest suggested that requesting team were not alerted to the suspicious outcome of the Deceased's November 2020 scan because it was an <u>expected</u> finding; as stated above, I was told that the radiologist's report was not

	escalated or alerted to the clinical or multi-disciplinary teams because the requesting form had indicated that the scan was to rule out malignancy and the outcome was not, therefore, treated as unexpected. I am concerned, therefore, that the same could happen again, despite the changes which have been made. I did not consider that [redacted] was able to address this concern satisfactorily in his evidence. Concern 2: The new electronic system is introducing a "read receipt" feature which, if used, would enable identification of reports which have not been opened and read by the requesting team in a timely manner. I am concerned, however, that the use of the read receipt is optional as this will inevitably undermine the extent to which any monitoring system will be able to spot and identify unread reports. I did not consider that either [redacted], nor the Consultant Colorectal Surgeon from whom I heard evidence about the plans for monitoring in the surgical department of Queens Hospital, were able to address this concern satisfactorily in their evidence.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing the concerns set out above and I believe your organisation has 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 **the 14th September 2023**. I, as 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 Family of Peter John Harris. I am also under a duty to send the Chief Coroner a copy of your response. 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 by the Chief Coroner.
9	**20th July 2023** **Alison Hewitt**