REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) [redacted], Chief Executive, Royal Free London NHS Foundation Trust**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner North 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.
3	**INVESTIGATION and INQUEST** Barbara Rawlinson died on 16 July 2015, aged 58 years, from complications arising from a diagnosis of uterine sarcoma. An inquest into her death was heard on 11 November 2015, at which I recorded a narrative conclusion (see attached).
4	**CIRCUMSTANCES OF THE DEATH** Mrs Rawlinson presented to her GP in 2014 with post-menopausal bleeding and was referred to the gynaecology team at Barnet Hospital (part of the Royal Free Trust). She underwent ultrasound examinations and hysteroscopies to investigate the cause of this bleeding, which was presumed to be resulting from a fibroid. She was concerned that the diagnosis was cancerous and, in order to reassure her that this was not the case, she underwent a hysterectomy in early 2015. Unfortunately histology of her uterus demonstrated that the cause of the bleeding was a uterine sarcoma. She was referred to UCLH to receive further treatment of this cancer and underwent a further procedure to remove additional tumour mass which had been demonstrated on CT scanning. Unfortunately, following this procedure she developed a perforated stomach and subsequently a perforated gallbladder. She died after attempts to treat these and further complications. Mrs Rawlinson's family raised a concern that no CT scanning had been undertaken prior to the hysterectomy being performed. Mr Broadbent, Consultant Gynaecologist at Barnet Hospital, had been appraised of this concern in writing before the inquest and had provided a supplementary written statement to address this. He set out that he had been reassured by the findings of repeated ultrasound scanning. As such, I did not call him to give evidence. However, at the inquest I heard from [redacted], Consultant Gynaecologist at UCLH who had undertaken Mrs Rawlinson's second operation. She set out that, in her opinion, a CT scan should have been undertaken prior to the hysterectomy to address the possible (but rare) diagnosis of sarcoma in a post-menopausal woman with ongoing bleeding.

	I decided that I could conclude the inquest but that this issue warranted a report to prevent future deaths, in order to allow the Royal Free Trust the opportunity to reflect on and respond to these concerns.
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) The lack of CT scanning prior to hysterectomy, with reliance only on ultrasonography, raises the concern that the diagnosis of uterine sarcoma could be missed in the future and consideration should be given as to whether steps can be taken to address this risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the addressee, 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 26 January 2015. 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, Mrs Rawlinson's family, Mrs Rawlinson's GP and the other NHS Trust involved. 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	**1 December 2015** **Assistant Coroner R Brittain**