REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mid Yorkshire Teaching NHS Trust** **2. Royal College of Radiologists**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East).
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 Coroner's (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 11th March 2022 I commenced an investigation into the death of Ms Samantha Jade Shillito, aged 38. The investigation concluded at the end of the Inquest on 30 November 2023. A narrative conclusion was reached which recorded Ms Shillito's medical history of alcoholic liver disease and depression. During a hospital admission in February 2022, she underwent an ascitic tap procedure that inadvertently perforated an artery, causing intra-abdominal bleeding that resulted in her death two days later. Within hours of the procedure, she was prescribed oramorph and other pain-relieving medications. The deterioration in her condition did not trigger a medical review and hence an opportunity was lost on the weekend of 25/26 February to initiate treatment to ameliorate this deterioration. She died on Sunday 27 February 2022 in Pinderfields Hospital, Wakefield. The medical cause of her death was attributed to (1a) intra-abdominal bleeding due to (1b) ultrasound guided ascitic tap and (2) cirrhosis, alcohol related liver disease.
4	**CIRCUMSTANCES OF THE DEATH** Ms Shillito was significantly unwell when admitted to hospital on 16/1/22. The inquest heard evidence that her mortality risk was around 40%. She provided verbal consent to the ascitic tap procedure but was not told there was a rare possibility of death if a surrounding structure were to be perforated. It appeared the procedure had been accomplished uneventfully on Friday 25/2/22, but within hours she complained of pain around the site of the procedure. On the Friday evening and during Saturday (25/26 February) her condition deteriorated, yet she was not reviewed or examined, nor were any other investigations initiated which may have halted this decline. On Sunday 27 February she was found in an unresponsive condition and died that day. Her family had not been forewarned of the seriousness of her illness, nor that her life was in danger and consequently went home some hours before she died.
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) There were no relevant specialist consultants in the hospital on the night of Friday 25/2/22, during Saturday 26/2/22 or on Sunday 27/2/22. Ms Shillito had a NEWS score which should have triggered an escalation of her treatment, but she was neither reviewed, examined properly or subjected to further

	investigations (such as blood tests and/or a CT scan) to establish the cause of her deterioration. Evidence was heard at the inquest from a consultant hepatologist to the effect that this was a missed opportunity to initiate remedial action when her deterioration could have been halted and her condition improved. (2) The ascitic tap procedure was said to be commonly undertaken and was regarded as low risk. The inquest was, however, unable to establish the magnitude of the risks of bleeding, infection or perforation of surrounding structures by reference to the medical literature or statistical evidence. How then can it be said to be a low-risk procedure if the inherent risks have not been quantified? This was viewed as a national (if not an international) problem, which requires published evidence to inform radiological practice. (3) The practice at the hospital was to obtain verbal consent to the procedure from the patient in the minutes before it took place. A consultant radiologist acknowledged that the risk of death was not mentioned to Ms Shillito. It is questionable whether this can be considered to be a patient's informed consent when the risks outlined are not reliably established, are not explained and the patient is not asked to sign a document. If there is a risk of death, irrespective of its rarity, the patient is entitled to be informed. This concern is highlighted when one considers the patient's medical condition and their likely emotional state, in circumstances which allow no time for reflection or discussion with other family members. It appears that no leaflet describing the ascitic tap procedure and the associated risks has been provided either by the Royal College of Radiologists or the hospital. (4) Ms Shillito's family were not made aware of the seriousness of her underlying illness. No effective communication was provided to them even on Sunday 27 February to help them appreciate the gravity of her situation. Her husband and her mother informed the inquest that they had not been told that she might die. In consequence, the shock of her death on the evening of Sunday 27 February 2022 was all the greater. It is acknowledged that this concern did not contribute to Ms Shillito's death, but it underlines the need for compassion and candour when dealing with patients and their families.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1 February 2024 (extended to take account of the forthcoming Christmas holiday). 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: [redacted] (deceased's husband) [redacted] (deceased's mother) [redacted] (deceased's stepmother)

	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 December 2023 Signed: Kevin McLaughlin Senior Coroner West Yorkshire (East)