



The  
Coroner's  
Service

North London Coroner's Service,  
Barnet, Brent, Enfield, Haringey and Harrow,  
Barnet Coroner's Court,  
20 Wood Street, London N4 3JF

E-mail [REDACTED]

Date: 11 October 2024

Our Ref: [REDACTED]

	<p><b>Annex A</b></p> <p><b>REGULATION 28: REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO: -</b></p> <ol style="list-style-type: none"><li><b>1. Homerton Healthcare NHS Foundation Trust</b></li><li><b>2. The British Society of Gastroenterology</b></li><li><b>3. The Royal College of Radiologists</b></li><li><b>4. The Royal College of Pathology</b></li></ol>
1	<p><b>CORONER</b></p> <p>I am Laura Bradford, Assistant Coroner for the North London Coroner Service.</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p> <p><a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a></p> <p><a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a></p>

## INVESTIGATION and INQUEST

On 17th January 2024 an investigation was commenced into the death of Kingsley Efosa IMAFIDON. The investigation concluded at the end of the inquest on 4 October 2024. The conclusion of the inquest was:

1a Intra -abdominal haemorrhage

1b Post liver biopsy for jaundice

1c Liver cirrhosis

1d ---

II Sickle cell disease

I recorded the following narrative conclusion:

Kingsley Efosa Imafidon had a medical history of homozygous sickle cell disease. On 29 November 2023, Mr Imafidon underwent a scheduled liver biopsy in order to investigate potential liver disease. Part of the device during the biopsy was deployed outside of the liver which later led to the procedural complication of bleeding into the peritoneal cavity, which led to Mr Imafidon's death.

## CIRCUMSTANCES OF THE DEATH

Kingsley was born with Homozygous Sickle Cell Disease (HbSS). In May 2023 his liver function tests were noted to be significantly deranged with worsening jaundice and he was referred to the gastroenterology team at Homerton Hospital. He underwent non-invasive imaging (ultrasound elastography) on 22 November 2023 which was suggestive of underlying cirrhosis. Blood tests also identified that his bilirubin was high and his elastography was high, consistent with cirrhosis. It was confirmed that a liver biopsy was required to understand the likely cause of the liver disease.

Kingsley underwent a clotting screen on 27 November 2023 prior to the biopsy to check that his INR was below 1.4 so the procedure could take place, in accordance with Homerton Healthcare NHS Foundation Trust's ("the Trust") policy. Kingsley's INR on this date was 1.3.

The liver biopsy took place on 29 November 2023 and the circumstances of this are outlined in the narrative conclusion in the box above, although these findings were not known until after the procedure had taken place.

Following the procedure Kingsley was transferred to the Medical Day Unit where he remained for four hours before being discharged at 16:30. This was the standard period of observation for all patients.

On 2 December 2023, Kingsley's family visited him at his home address and found him lying unresponsive in his bed. The post mortem examination found evidence of extensive fresh haemorrhage into the free peritoneal cavity following the biopsy, which the post mortem report indicates was the immediate cause of death.

**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. –

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- There was no apparent liaison between the teams involved in Kingsley's care to consider any matters that may be relevant to his HbSS prior to the biopsy being carried out;
- The Trust's Standard Operating Procedure ("SOP") for Elective Liver Biopsy does not appear to give consideration to patients with other pathologies such as HbSS;
- There was no apparent consideration given to potential additional post-operative monitoring or requirements for a patient with HbSS;
- The Trust's SOP refers to a document titled "*Guidelines on the use of liver biopsy in clinical practice from the British Society of Gastroenterology, the Royal College of Radiologists and the Royal College of Pathology*" (Neuberger J, Patel J, Caldwell H et al. Gut 2020) which provides advice on liver biopsy techniques, methods and aftercare etc. These guidelines do not appear to give consideration (and therefore guidance) in relation to the use of liver biopsy for patients with other pathologies such as HbSS.

**ACTION SHOULD BE TAKEN**

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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.

**YOUR RESPONSE**

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You are under a duty to respond to this report within 56 days of the date of this report, namely by 07 December 2024. 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.

**COPIES and PUBLICATION**

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

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- Kingsley's family
- I have also sent it to [redacted] at the Liver Unit, University Hospitals Birmingham NHS Foundation Trust who I believe may find it useful or of interest.

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.

11 October 2024

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Signature

for Laura Bradford Assistant Coroner for North London