REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England**
1	**CORONER** I am Dr Anton van Dellen, HM Assistant Coroner, for the coroner area of West 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** An investigation was commenced into the death of Samsam Haji Ali Ateye, aged 68. The investigation concluded on 30 August 2024. The conclusion in the inquest was: *Complications following surgical procedure.* The medical cause of death was 1a Multiorgan failure 1b Following bio prosthetic aortic valve replacement surgery 1c Aortic stenosis with ventricular hypertrophy and fibrosis II Disseminated intravascular coagulopathy and thrombocytopenia with microvascular thrombotic involvement of hands and feet (managed conservatively), adult respiratory distress syndrome and acute bronchopneumonia
4	**CIRCUMSTANCES OF THE DEATH** Samsam died on 12 May 2023 at Harefield Hospital, Uxbridge. She had been diagnosed with severe aortic stenosis which was symptomatic. A Multi-Disciplinary Team (MDT) meeting decided that she would benefit from aortic valve replacement surgery. She had an out-patient pre-operative Covid-19 Polymerase Chain Reaction (PCR) test performed on 18 April 2023, which was negative. She was admitted to hospital on the day of her surgery on 20 April 2023. On admission, she had another Covid-19 PCR test performed on her that morning, before her surgery. She had aortic valve replacement surgery that afternoon. Post-operatively, the surgeons who operated on her became aware, that evening, that the Covid-19 PCR test performed on her on the morning of surgery was positive. A subsequent three further Covid-19 tests performed in hospital after 20 April 2023 were also positive. Post-operatively, she developed episodes of atrial fibrillation, as well as sepsis which was probably bacterial and was of unknown origin. She died due to sepsis which caused Multi-Organ Failure. The inquest heard evidence that the consultant surgeon was very worried upon learning that Samsam was Covid positive as patients who are Covid positive who undergo cardiac surgery have a real risk of excessive complications and mortality. The inquest heard that policy about pre-operative testing for Covid for cardiothoracic surgery and the form of that testing was formulated at a national level by NHS England.

5	**CORONER'S CONCERNS** During 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. The policy for testing for Covid-19 before cardiac surgery, specifically valve replacement surgery..
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 29th October 2024. 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: 1. [redacted] 2. [redacted] 3. [redacted] 4. [redacted] 5. [redacted] 6. [redacted] 7. [redacted] 8. [redacted] 9. [redacted] 10. [redacted] 11. [redacted] 12. [redacted] 13. [redacted] 14. [redacted] 15. [redacted] 16. [redacted] 17. [redacted] 18. [redacted] 19. [redacted] 20. [redacted] 21. [redacted] 22. [redacted] 23. Guys and St Thomas' NHS Foundation Trust 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	**3rd September 2024**