REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **[redacted] — Royal Free Hospital Chief Executive** **Pond St, London NW3 2QG**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner London North.
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	**INVESTIGATIONS and INQUESTS** John Tompkins (date of birth 11/9/50) died on 25 July 2024 at Royal Free Hospital (RFH), following treatment received for a diagnosis of hepatocellular carcinoma. Mr Tompkins had been admitted to Royal Free Hospital in July 2024 and underwent a hepatic artery embolisation and right-sided portal vein embolisation. These were requested to be undertaken sequentially, following a multi-disciplinary team (MDT) meeting. However, owing to how the requests had been received, they were undertaken at the same time. Before the procedures were undertaken, attempts were made to discuss the MDT plan with the surgical Consultant. However, he was on leave and not contactable. Mr Tompkins subsequently developed acute-on-chronic liver failure and sadly died from consequential multiorgan failure on 25 July 2024. I heard the inquest into his death on 6 December 2024 and reached a narrative conclusion as follows: *Mr Tompkins died from a recognised complication, arising from necessary medical procedures. These procedures were undertaken simultaneously, rather than sequentially, as had initially been intended. This simultaneous approach more than minimally contributed to his death.* At the inquest there was limited evidence as to what steps had been taken by RFH to address the risk of future deaths occurring in similar circumstances, including issues with how requests for procedures were undertaken, whether consent for these procedures included the risk of death and how novel procedures are considered by RFH before they are implemented. Following the inquest I received a response from RFH which predominantly addressed the points raised (attached entitled 'Procedure Requesting Process). Additional recommendations were raised in this response, regarding the National safety standards

	for invasive procedures (NatSSIPS2), a standard which was not highlighted at the inquest. Subsequent to receipt of the RFH response, Mr Tompkins' family raised concerns (attached entitled 'Appendix 1') that, *inter alia*, the Trust had not followed the NatSSIPS2 standards whilst undertaking the two procedures.
4	**CIRCUMSTANCES OF THE DEATH** See box 3.
5	**<u>CORONER'S CONCERNS</u>** During the course of this inquest and subsequently, 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** following the inquest into Mr Tompkins' death were as follows: 1. I am concerned that there was limited internal review of the circumstances of Mr Tompkins' death, following identification that the procedures were undertaken at the same time; 2. Further and linked to the above, I am concerned that the Trust seemingly did not consider the NatSSIPS2 standards either when undertaking the procedures, nor in detail as part of its review following the inquest.
6	**ACTION COULD BE TAKEN** In my opinion action could 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 8l April 2025. 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, Mr Tompkins' family, the hospital Trust and the CQC. 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	11 February 2025

	 **Assistant Coroner R Brittain**