Care Quality Improvement Directorate
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[redacted]

Assistant Coroner R Brittain,
Manor House Dr
Coventry
England
CV1 2ND

30 January 2025

Subject
Royal College of Physicians response to Regulation 28 report to prevent future deaths

Dear Assistant Coroner R Brittain,

The Royal College of Physicians (RCP) notes with concern the content of the Regulation 28 report for the prevention of future deaths related to the death of Man Yin 'Anita' Ng. We send our sincere condolences to the family of Mrs Ng.

This regulation 28 report is addressed to the RCP, and we have consulted neurology experts, acute medicine and general medicine experts, including our Patient Safety Committee.

The RCP notes the matters of concern raised in this report, particularly the concerns about the processes surrounding the treatment of subarachnoid haemorrhage. Many of those who present with such a clinical problem in the acute hospital setting will be picked up by emergency departments and transferred to the neurosurgeons for further management directly. In this case, Mrs Ng, who presented to a centre with a dedicated neurosurgical unit (at Coventry and Warwickshire hospital), did not have the delay which can be associated with transfer from centres without neurosurgery on site. However, the Royal College of Physicians wish to make clear that in the case where there is no neurosurgical unit, for example, a district general hospitals, pathways should be in place and do exist for transfers to be facilitated as quickly as possible for patients to receive specialist treatment. There can be delays in transfer when the neurosurgical units are full and this might be when a patient is admitted into an acute medical admissions unit to await transfer. We also note the nine hour delay from the time of presentation to the emergency department until review by a doctor and we continue to campaign on this matter as we hear from our clinicians the very concerning impact on patient outcome, as a result of unacceptable delays in emergency care.

Whilst awaiting transfer, the neurosurgeons may request further imaging such as a CT angiograph to identify aneurysms or bleeding points, although in many cases as soon as the original bleed is identified, permission will be obtained to proceed to an angiography and consent obtained as this investigation involves the use of contrast. Furthermore, occasionally, those presenting with classical signs and symptoms of a subarachnoid haemorrhage may initially have normal imaging and require a lumbar puncture which can delay diagnosis but, as soon as it is identified, patients are discussed with the neurosurgeons. Ideally, a patient should be transferred for intervention as early as possible.

There is variability in the interventional radiology services which may be available in relation to timing of intervention but also the safest time to proceed. In Mrs Ng's case there were delays due to issues with resources and staffing. These are noted to be relatively unusual in our experience. If indeed, Mrs Ng had presented to a hospital without a dedicated neurosurgical unit, the delay may have been greater. Furthermore, we recognise that the procedure itself carries a haemorrhage risk and sadly for Mrs Ng's family, we will not know whether, even if she had had the intervention in a timely manner, the aneurysmal sac/blood vessel walls would have been so thin and friable that she would sadly have been at risk of a re-rupture during the intervention. The risk with all intracranial/ subarachnoid haemorrhages is that they can extend.

As you mention within the Regulation 28, much of the input into the treatment of such patients falls under the purview of interventional radiologists and our physicians are mainly involved in the initial identification of a subarachnoid haemorrhage, initial referral and sometimes investigation and where necessary, if someone needs repatriation acceptance back for rehabilitation. Whilst we acknowledge your comments about interventional radiologists not having direct admitting rights, there is safety for such patients to be admitted under core specialties such as neurosurgery. The safety, for example, of those patients requiring angioplasty instead of vascular surgery in district hospitals may fall under medicine. This should provide oversight, for example, in a way the bloods can be rechecked after the intervention and pre/post hydration can be organised for those at risk of kidney failure due to the use of contrast.

We would support the NICE guidance of an MDT approach, with a discussion between interventional radiology and neurosurgery to ensure the best approach and ofcourse, patient and carer involvement.

In asking for our guidance as to who is best to manage patients with this condition, we would state that the neurosurgeons and linked MDT are best placed to manage these patients, especially due to the fact that not all centres have a dedicated neurosurgical service or neuro-interventional service and the importance of such patients being managed by these specialist teams rather than delay treatment options. This enables appropriate protocols to be in place for the safe and effective use of such services and offers the best outcomes for patients. This said, unfortunately the nature of subarachnoid haemorrhages is such that re-rupture is unpredictable, including primary rupture, and even the best neurosurgeons who manage the complex aneurysms cannot predict whether someone may rupture before intervention can be done in a safe and timely manner. Without an anaesthetist present, it would not have been safe to proceed and it may have been that if the thrombectomies, which took priority on the 20 Jan 2025, had been delayed that the patients may have suffered similar catastrophic consequences.

Indeed, the NICE guidance of the management of aneurysms causing subarachnoid haemorrhages is clear: "An interventional neuroradiologist and a neurosurgeon should discuss the options for managing the culprit aneurysm, taking into account the person's clinical condition, the characteristics of the aneurysm, and the amount and location of subarachnoid blood. They should document a proposed treatment plan based on the following options:

- endovascular coiling
- neurosurgical clipping
- no interventional procedure, with monitoring to check for clinical improvement and reassess the options for treatment."

We would strongly support that the pathways remain unchanged and given both complications and the original ruptured aneurysm if coiling is not feasible remain under the care of the neurosurgeons.

We are happy to discuss this further with the Royal College of Surgeons and the Royal College of Radiologists if necessary. Once again, our sincere condolences to Mrs Ng's family at this difficult time.

Yours sincerely,

MBChB FRCP BSc (Hons) LLM
Clinical Director for Patient Safety and Clinical Standards