NHS
Whittington Health
NHS Trust

[redacted]
Acting Chief Medical Officer
Medical Directorate
Jenner Building
Magdala Avenue
London N19 5NF

[redacted]
www.whittington.nhs.uk

03/08/2026

To:
Senior Coroner ME Hassell
Inner North London Coroner's Court

Response to Regulation 28: Prevention of Future Deaths Report

Re: Linda Green (died 22nd November 2025)

Dear Senior Coroner Hassell,

Thank you for your Regulation 28 report dated 11 June 2026 concerning the very sad death of Mrs Linda Green, aged 66 years. You concluded her inquest on 8 June 2026. On behalf of Whittington Health NHS Trust, I wish again to express our condolences to her family.

We take the concerns you have raised extremely seriously. This response sets out the actions we have already taken and those we are committed to undertaking to ensure learning, improvement, and prevention of similar future deaths.

Sadly, cerebral air embolism is a rare but devastating complication of elective oesophageal balloon dilatation. It is therefore important that the learning we are taking forward is able to meaningfully attempt to reduce the risk of death in the event of this rare event occurring again.

Details of action taken

Following Mrs Green's death, the Trust undertook a comprehensive programme of investigation, service improvement and organisational learning to reduce the risk of a similar event occurring in the future. The actions taken have focused on strengthening clinical processes, introducing a formal

emergency pathway, improving staff awareness and embedding learning across the organisation and beyond.

1. Patient Safety Incident Investigation

A Patient Safety Incident Investigation (PSII) was undertaken by a consultant gastroenterologist who had not been involved in Mrs Green's care. The investigation has been presented at the Whittington Improvement Safety Huddle (WISH), and all recommendations arising from the investigation have now been implemented with work ongoing to embed into clinical practice.

The PSII identified three key areas for improvement:

- raising awareness of air embolism as a rare but serious complication of endoscopic procedures;
- developing a formal referral pathway for patients requiring Hyperbaric Oxygen Therapy (HBOT); and
- strengthening post-procedure communication through a structured multidisciplinary debrief.

As a result, it has been agreed that following all endoscopic dilatation procedures, whether undertaken under general anaesthesia or conscious sedation, there will be a structured post-procedure "time out". This provides an opportunity for all members of the multidisciplinary team involved in the patient's care to review the post-procedure recovery plan, clarify ongoing management and raise any peri-procedural concerns before the patient leaves the procedure area.

2. Development of the Air/Gas Embolism and Emergency HBOT Pathway

Recognising the importance of rapid diagnosis and treatment, the Trust commissioned the development of a dedicated **'Air/Gas Embolism Management and Emergency Hyperbaric Oxygen Therapy (HBOT) Pathway'**, written by the Clinical Lead for Critical Care Medicine, Dr James Goddin.

The pathway has been formally adopted as Trust guidance and is available to all clinical staff. There is a programme commencing to actively disseminated to anaesthetic and critical care teams to ensure that the guidance is not simply available but understood and incorporated into clinical practice.

The pathway includes:

- identification of procedures associated with a risk of air or gas embolism, recognising that this complication is not confined to endoscopy;
- guidance on recognising air embolism, acknowledging that diagnosis can be challenging because the clinical presentation—reduced consciousness and cardiovascular instability—may mimic more common complications associated with sedation or anaesthesia;

- emphasis that delayed recovery of consciousness should prompt early review by the responsible anaesthetist and consideration of air embolism within the differential diagnosis;
- immediate management recommendations, including urgent CT imaging for any patient with unexpectedly prolonged recovery or abnormal neurology, recognising that alternative diagnoses such as peri-procedural stroke must also be considered;
- early escalation to Critical Care, the ACCESS transfer team and a Hyperbaric Oxygen Therapy service where appropriate.

The pathway also includes comprehensive contact details for Hyperbaric Oxygen Therapy services across the United Kingdom. Although the Whipps Cross HBOT service had provided regional access for many years, its decommissioning shortly before Mrs Green's death highlighted the importance of ensuring clinicians have immediate access to (more than one) alternative centres capable of providing emergency treatment.

3. Education and Organisational Learning

The Trust is undertaking a programme of education to ensure that the learning from Mrs Green's case is disseminated widely.

Within the Endoscopy Unit, the case has been presented on two occasions as part of the Learning Corner at the monthly Endoscopy User Group (EUG), attended by medical and nurse endoscopists together with the wider multidisciplinary team. The case will continue to be revisited at the next EUG meeting to share the outcome of the Coroner's Inquest and introduce the new HBOT pathway.

On 25 June 2026, the case formed the focus of a Joint Anaesthetic and Critical Care Improvement Afternoon. The presentation included Mrs Green's clinical course, the findings of the PSII, the Coroner's conclusions, the Regulation 28 Prevention of Future Deaths Report and the newly developed HBOT pathway. The session was attended by consultant anaesthetists, critical care clinicians and the consultant gastroenterologist who undertook the PSII.

Learning has also been disseminated through the Trust's governance processes. A summary of Mrs Green's case has been presented through the Whittington Improvement Safety Paper (WISP) and included within the Learning from Deaths report presented to both the Quality Assurance Committee (QAC) and the Quality Governance Committee (QGC). The case will also feature in the Trust's quarterly Learning from Deaths newsletter, which is distributed to mortality leads across the organisation for further local dissemination.

4. Wider System and National Learning

The Trust recognises the importance of sharing learning beyond the organisation.

The Whittington gastroenterology team will present the case at the next North Central London (NCL) Endoscopy Board to raise awareness across the local healthcare system.

In addition, the consultant gastroenterologist who undertook the PSII has approached the British Society of Gastroenterology (BSG) to explore opportunities for sharing the case nationally with its members, with the aim of supporting wider professional learning and reducing the likelihood of similar incidents occurring elsewhere.

The Trust considers that the actions undertaken address the concerns identified by the Coroner through improvements to clinical pathways, multidisciplinary communication, staff education and wider dissemination of learning. The Trust will continue to reinforce this learning through its established governance, education and quality assurance processes, and will monitor compliance with the new pathway and post-procedure debrief process through routine clinical governance arrangements.

[redacted]

[redacted]

Chief Medical Officer
Whittington Health NHS Trust