	Report to Prevent Future Deaths **Regulation 28 of** **The Coroners (Investigations) Regulations 2013** **Linda Lucille Victoria GREEN (died 22.11.25)**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Poplar Coroner's Court Bow Coroner's Court
2	**DATE OF REPORT** 11 June 2026
3	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
4	**THIS REPORT IS BEING SENT TO:** 1. Chief Executive Whittington Health NHS Trust You are under a duty to respond to this report within 56 days of the date of this report, namely by 6 August 2026. I, the coroner, may extend the period if an appropriate application is made.
5	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner.

	In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe that you have the power to take such action.
7	**INVESTIGATION AND INQUEST** On 17 December 2025, I commenced an investigation into the death of Linda Green, aged 66 years. I concluded the inquest on 8 June 2026. I recorded a medical cause of death of: 1a hypoxic-ischaemic brain injury 1b cerebral air embolism 1c oesophageal mucosal tear complicated by pneumomediastinum following elective oesophageal balloon dilatation (21/11/25) 1d severe lymphocytic oesophagitis with stricture 2 rheumatoid arthritis
8	**CIRCUMSTANCES OF DEATH** Linda Green died as a result of a complication of medical treatment. She underwent an oesophageal balloon dilatation at 9.30am on 21 November 2025 at the Whittington Hospital in London. This lasted approximately 10 minutes. Unbeknown at the time to those treating her, the procedure caused an oesophageal perforation that resulted in a cerebral air embolism. This led to her not waking up from the anaesthetic and ultimately killed her.

	The perforation and pneumocephalus were diagnosed at 1.30pm. She did not leave the hospital for transfer to a hyperbaric oxygen unit until 6pm. She died the following day at the James Paget University Hospital in Great Yarmouth.
9	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: I was told at inquest that, at the time of Ms Green's death, there were only 6 hyperbaric oxygen chambers in the country and none in London. I heard that considerable time was spent by staff at the Whittington Hospital trying to locate their nearest unit. There had been a unit in East London at Whipps Cross Hospital, and this appeared online to be operational. However, the staff eventually discovered that this had been decommissioned. This was when they approached the James Paget Hospital in Great Yarmouth. I heard that, as a result of Ms Green's death, the unit at Whipps Cross Hospital has re-opened temporarily for one year. However, Ms Green's treating consultant anaesthetist gave evidence at inquest that she did not know this. She also told me that the Whittington still does not have a pathway for use in such situations. As a starting point, she explained that some anaesthetists are unlikely to be aware that endoscopists may not necessarily know that a perforation has occurred during the procedure, and will not have the potential for pneumocephalus in their thinking. It seems to me that all relevant healthcare professionals should have information about the location of the nearest operational hyperbaric oxygen chamber, and I was told that the trust should have a clear pathway for anaesthetists and gastroenterologists regarding the care and transfer of patients who do not wake up after oesophageal dilatation.
10	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every interested person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest.

	I have sent the report to: • the family of Linda Green • NHS England • Royal College of Anaesthetists • Association of Anaesthetists. I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 5 above for additional information relating to the publication of reports and responses.
	SIGNATURE *ME Hassell*