Barking, Havering and Redbridge
University Hospitals
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PRIVATE AND CONFIDENTIAL
Her Majesty's Senior Coroner
Walthamstow Coroner's Court
Queen's Road
E17 8QP

BY EMAIL ONLY: [redacted]
Date: 9 August 2017
Our ref: 0319

RECEIVED
10 AUG 2017

Trust Response to Regulation 28 Report

Dear Madam

Kevin George Mann

In Response to the Regulation 28 Report you made at the conclusion of the inquest into the above-named's death on 15 June 2017, please find herewith the Trust's Response.

Brief Background

Mr Mann underwent an Ivor Lewis procedure for oesophageal cancer on 23rd May 2016. On the 27th May 2016 reduced entry into the left side of his chest was noted and an x-ray confirmed a large left-sided pneumothorax. The surgical team requested a further chest x-ray at 2:30pm. The consultant surgeon confirmed that this should have been carried out prior to the Visipaque procedure. The chest x-ray was not carried out and the Visipaque procedure took place at 16:10 on 27th May 2016. The independent radiology expert confirmed that from the very first image available to the radiologist, the left pneumothorax was apparent. The radiologist should not have commenced the swallow procedure. The procedure was commenced and contrast material was seen to enter the left main bronchus. Despite this, the procedure continued and further contrast material is seen entering the left lung. Following the procedure there was a clinical deterioration in Mr Mann's respiratory condition.

On the 28th May 2016 Mr Mann suffered a further deterioration in his clinical condition and required re-intubation and ventilation. From this time there was no significant or sustained recovery. He passed away at Queens Hospital on the 7th September 2016. The cause of death was found to be 1a: Acute Respiratory Distress Syndrome 1b: Chemical Pneumonitis and Pneumothorax 1c: Oesophageal Carcinoma (Ivor Lewis procedure).

Coroner's Concerns

1. An independent radiology expert confirmed that the left pneumothorax was clearly apparent

from the imaging, prior to the swallow commencing. The independent expert, consultant surgeon and consultant intensivist all agreed that the procedure should not have been carried out, in light of the pneumothorax.

2. The radiologist who performed the procedure did not check the radiology system prior to commencing the swallow procedure. Had she checked the system she would have seen the x-ray taken at 12:37 showing a large left pneumothorax. She would also have seen the outstanding request for a chest x-ray. Both the independent radiology expert and the Trust's radiology witness (Dr G) confirmed that recent radiology should be checked by the radiologist prior ti performing this procedure.

3. The radiologist continued with the procedure after becoming aware of the passage of contrast material into the left main bronchus. The consultant surgeon and independent radiologist confirmed that the procedure should have been abandoned at that stage.

4. There was no documentation available within the records of the amount of contrast handed to Mr Mann or the amount of contrast ingested by him.

5. The policy in place regarding the Visipaque procedure does not require documentation of the amount of contrast material used, or for preliminary checks to be undertaken. The incident occurred over a year ago. Despite clear concerns being raised by the consultant surgeon on 27 May 2016, there had been no adequate review of the Visipaque procedure policy, by the date of the inquest hearing.

Trust Response

The Trust accepts and acknowledges that there was clinical governance gap in relation to its Visipaque procedures. As a result of the Regulation 28 report made in this case, the Trust has undertaken reflection on issues raised in this case and has gained insight on the lessons to be learned.

The Trust's Radiology Department has carried out an audit of Visipaque Swallows from May 2016 – June 2017 and will conduct a further audit three months after the revised Protocol (attached) has come into use to ensure understanding and compliance. If any issues are identified by the audit, the staff concerned will have 1:1 conversations with one of the Clinical Leads for Radiology and be required to undergo an observed procedure for assurance of skill.

The updated protocol also recognizes the need for specific informed consent to be obtained from the patient prior to Radiology procedures being undertaken. Obtaining such consent is in line with guidance from the GMC, the Department of Health and is usually part of any NHS Trust's consent policy. Whilst the Referring clinician (recommending the scan) has overall responsibility for the patient and has the most accurate clinical information on the patient, the Protocol provides communication guidelines between the Radiologist and the Referring clinician in order that any underlying pathology or existing comorbidities which may have a significant contrast risk can be noted and discussed, for the best clinical management of the patient prior to any radiology investigations being conducted.

Patients will be continuously monitored when presenting for Visipaque swallow investigations –

whether they are inpatients or outpatients and should any questions arise from the patient on the day of the scan or x-ray, appropriate clinicians will be available to answer those questions.

I trust the above Response, with attached Protocol addresses your concerns. If I can be of any further assistance, please do not hesitate to contact me.

Yours sincerely

[redacted]
Medical Director