REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Matthew Hopkins, Chief Executive, Barking, Havering & Redbridge University Hospitals NHS Trust. Executive Offices, Queens Hospital, Rom Valley Way, Romford, Essex, RM7 0AG.**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the Coroner Area of East London
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 14th September 2016 an investigation commenced into the death of Mr Kevin George Mann. The conclusion of the Inquest was a narrative conclusion: *Mr Mann underwent a necessary surgical procedure - Ivor Lewis surgery- on 23rd May 2016. He had a poor post-operative recovery, which required prolonged ventilation. On 27th May 2016 he developed a pneumothorax. On the 27th May 2016 he also underwent a Visipaque contrast study. He should not have undergone the Visipaque procedure at that time, due to the pneumothorax. During the course of the Visipaque procedure, contrast entered the left main bronchus. Both the post-operative complication of pneumothorax and the entry of contrast material into the left main bronchus led to a deterioration in his respiratory state, from which he did not recover.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Mann underwent an Ivor Lewis procedure for oesophageal cancer on the 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 2:30 pm. 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 around 16:10 on the 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 in 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 and 1c: Oesophageal Carcinoma (Ivor Lewis

	procedure).
5	**CORONER'S CONCERNS** During the course of the Inquest evidence gave rise to the following matters of concern:- 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 the large left pneumothorax. She would also have seen the outstanding request for a chest xray. Both the independent radiology expert and the Trust radiology witness (Dr G), confirmed that recent radiology should be checked by the radiologist prior to 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have 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 **10 August 2017**. 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 and to [redacted] the CQC and the Director of Public Health, (Mr Mathew Cole). 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	**[DATE]** 15.6.17 **[SIGNED BY CORONER]**