	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **1. Professor Julia Wendon, Executive Medical Director, King's College Hospital, Denmark Hill, London SE5 9RS**
1	CORONER I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	INQUEST On 17th November 2016, I opened an inquest into the death of **Ms Hannah Barney, who died on 11.10.15 (0270-15) (PF) in Kings College Hospital** It was concluded on 6th June 2017. The medical cause of death was: 1a Multi-organ failure 1b Extensive soft tissue bacterial and fungal infection 1c Haemolysis, Elevated Liver Enzyme and Low Platelets syndrome of pregnancy causing liver failure and multiple thrombi; multiple broad spectrum antibiotics II Genetic Prothrombotic tendency The conclusion as to the death was by narrative which included: "After intensive medical treatment she was initially referred for surgical debridement of an infected groin haematoma on 11th, which was conducted on 16th and more urgently on 18th, she developed multi-organ failure..."
4	CIRCUMSTANCES OF THE DEATH The evidence of Prof Heneghan was: Between the 11th and 18th September she was acutely ill and required many specialist opinions and multi-disciplinary care. The tissue viability nurse considered urgent surgical opinion was needed on management of her infected wound. She saw a hepatologist and nephrologist on 12th, a weekend surgical team on call on 13th, the renal team on 15th and a hepato-biliary surgeon in theatre on 16th. The case was then discussed with a plastic surgery registrar, who suggested that an urgent full debridement should be undertaken but this could not be done at King's College Hospital since there was no on-call plastic cover, and would ultimately need to be performed at St Thomas Hospital. A gynaecology registrar attended on 17th. A scan was performed to exclude necrotising fasciitis and

	it was agreed that the general surgical consultant would take her to theatre. It was not until 18th when a multi-disciplinary team of gynaecologist, plastics, general surgery and orthopaedics back up was assembled and surgical debridement was performed but she died later in ITU.
5	CORONER'S CONCERNS During the course of the inquest, the evidence revealed a matter giving rise to concern that in my opinion means that there is still a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows. – The plastics surgical consultant, [redacted] who saw her on 18th and 21st gave an opinion that she had haematomas and severe sepsis, although the diagnoses of Fournier's gangrene or necrotising fasciitis had been considered. These conditions needed very urgent surgical treatment. He said that a few days delay in debridement could make a difference to the damage to surrounding tissues. . General surgeons are often reluctant to undertake such debridements and may not have the skills. He opined that having a sole consultant plastics surgeon practitioner in KCH was not safe. In cases of necrotizing fasciitis a small delay in surgery would mean death. He noted that KCH was a regional trauma centre. He considered future lives were at risk without a 24 hour consultant plastics service at KCH.
6	ACTION SHOULD BE TAKEN I send this report to KCH to draw your attention to this reported risk and copy it to NHS England and the Department of Health, as I believe that these bodies are in a position to take action.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday, September 4th 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. If you require any further information or assistance about the case, please contact the case officer, [redacted]

8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons: [redacted] (father) [redacted] (husband) I am also sending this report to the following, who may have an interest: [redacted] Department of Health NHS England Royal College of Surgeons St Thomas Hospital 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] 11th July 2017 [SIGNED BY CORONER]