Regulation 28: Prevention of Future Deaths report

Hariharan Harichandra (died 19.12.2019)

	THIS REPORT IS BEING SENT TO: [redacted] **Chief Executive** **Royal Free Hospital** **Pond Street** **London** **NW3 2QG**
1	**CORONER** I am: Edwin Buckett Assistant Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**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.
3	**INVESTIGATION and INQUEST** On the 6th January, 2020 an inquest was opened into the death of Hariharan Harichandra who died aged 65, on the 19th December, 2019 at The Royal Free Hospital, Pond Street, London, NW3 2QG. The investigation progressed to an inquest which I conducted between the 14th and 16th December, 2020. I made a determination at the conclusion of the inquest that Mr Harichandra had died as a result of cardio respiratory failure and that a fall from a wheelchair on the 5th December 2019 was the precipitating cause of his death.
4	**CIRCUMSTANCES OF THE DEATH**

	On 5th December 2019, Mr Harichandra, whilst in hospital, fell out of his own electric wheelchair and struck the floor. He was a long standing quadriplegic with a brittle spine. He had recently been placed in that wheelchair by hospital staff but not strapped in. He toppled forwards because he was sitting upright in the chair and not sitting leaning back into the chair. A hospital CT scan carried out on the same day revealed a clear and obvious fracture to his neck at C4/5 and a posterior displacement of the spine at the fracture site. That injury was caused by the fall. There was an error in the reporting of that CT scan by hospital staff such that the report which accompanied the scan images indicated there was no fracture. As a result Mr Harichandra was not accepted to the local spinal trauma centre hospital, where it is likely that an operation to stabilise the fracture would have been carried out had the CT scan been correctly reported. The precipitating cause of his death was the neck fracture sustained in the fall on 5th December 2019.
5	**CORONER'S CONCERNS** During the course of the inquest, the following evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. Evidence was given by medical staff from the Royal Free Hospital and other medical experts that: 1. There was an error in the reporting of the CT scan by the original clinician. 2. That error was not noticed when the CT scan was (or should have been) reviewed by a Consultant Radiologist. 3. The staff who moved Mr Harichandra to his wheelchair on the 5th December 2019 were not aware of his pre-existing spinal condition in particular his brittle spine. They did not make reference to the Falls Assessment Tool. Furthermore, that document was incomplete as it did not highlight his spinal condition and lack of mobility. 4. The staff who moved Mr Harichandra did not examine his wheelchair for a belt which would have kept him secure. They were unaware that such a device existed and as a result, did not consider whether it should be used.

	5. Mr Harichandra suffered a severe adverse reaction to the use of a Naso-Gastric tube on the 19th December, 2019 which was closely associated with terminal events. This fact was not recorded by hospital staff as it should have been. I am concerned that: (a) The error by the original clinician who interpreted the CT scan images of 5th December 2019 has not been properly explained. (b) The Consultant Radiologist who reviewed the CT scan images of the 5th December 2019 should have noticed the clear and obvious neck fracture. Although there were 2 scans of the 5th December 2019 to review, it appeared that the clinician most probably reviewed only one of them. There ought to be a system in place which ensures that a scan review can only be completed if <u>all</u> the scans taken are reviewed by a second clinician. (c) The Falls Assessment Tool was not properly completed or reviewed by staff; (d) Hospital staff have no training in how to assess and deal with private equipment brought from outside such as an electric wheelchair and the safety features of such devices; (e) By hospital staff not recording Mr Harichandra's adverse reaction to the Naso-Gastric tube insertion, future clinicians would have been unaware of this severe reaction when treating him and considering how his important nutritional needs should be met had he survived.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 by **5th March 2021.** 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 following. • HHJ Thomas Teague QC, the Chief Coroner of England and Wales; • [redacted] [address withheld] 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 5th January, 2021 SIGNED BY ASSISTANT CORONER EDWIN BUCKETT** *Edwin Buckett*