East London Coroners
MISS N PERSAUD
SENIOR CORONER
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
Telephone 020 8496 5000 Email: coroners@walthamforest.gov.uk

REF: 103771

6th November 2020

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]Chief Executive, The Barking Havering and Redbridge University NHS Trust, Queen's Hospital, Rom Valley Way, Romford, Essex, RM7 0AG – [redacted]
1	**CORONER** I am Nadia Persaud Senior Coroner for **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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 25th April 2016 I commenced an investigation into the death of Stanley Alfred Babbs. The investigation concluded at the end of the Inquest on the 30th October 2020. The conclusion of the Inquest was a narrative conclusion: *Mr Stanley Babbs died as a result of the administration of IV contrast for a CT scan. An individualised, personal evaluation and assessment was not carried out before the administration of contrast. A robust risk/benefit analysis had not been carried out prior to the administration of contrast. Mr Babbs had not been informed of the risks of administration of contrast. Communication between the referring clinician and the radiology team was deficient. Had a personalised assessment, risk/benefit analysis and robust communication been carried out, on the balance of probabilities, the CT scan with contrast would not have been performed and his death at that time would have been avoided.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Stanley Babbs was 91 years old. He had a past medical history of chronic kidney disease (stage 4), diabetes and heart failure. He had been generally well in 2015 but was noted on blood tests to have a low haemoglobin. His haemoglobin was within the target range for a patient with chronic kidney disease. Mr Babbs was referred to a gastroenterologist by his general practitioner. The gastroenterologist considered that a CT scan would be required to exclude a possible malignancy. Other than the chronically low haemoglobin, there were no other clinical indicators of malignancy. The CT scan

	was requested and a radiologist agreed that a contrast CT scan could take place, with appropriate hydration being administered. On the 21st January 2016 a contrast CT scan took place. Following this Mr Babbs became unwell and blood tests taken on the 25th January 2016 showed a very raised creatinine. He was diagnosed with a contrast induced acute kidney injury and admitted to hospital. During hospitalisation he required a catheter. Sadly, he succumbed to sepsis from a urinary tract infection and passed away in hospital on the 16th February 2016.
5	**CORONER'S CONCERNS** During the course of the inquest the 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. – The Royal College of Radiologist Standards for Intravascular Contrast Administration requires that the ultimate responsibility for intravascular contrast administration rests with the person who prescribes it. The Standards identify risk factors for acute kidney injury, to include chronic kidney disease (eGFR of less than 40); heart failure and age 75 years or older. The Standards identify that for those at risk of acute kidney injury, the dose of non-ionic iodine based contrast medium should be minimised, taking into consideration the indication and patient's body weight. It was noted at the Inquest hearing that a Practice Group Direction has been prepared for the administration of contrast to persons who are not at increased risk (those with an eGFR greater than 30). There is no such Practice Group Direction or other prescribing safeguards for patients at higher risk (eGFR lower than 30). The clinical lead for radiology at the Trust stated in his oral evidence that there is no prescription for contrast. This is so, even though contrast is a prescription only medicine. The clinical lead stated that a radiologist will simply say "contrast" or "no contrast". This is the case even for those patients who have a high risk of a contrast induced acute kidney injury. Patients with chronic kidney disease, diabetes, cardiac failure and aged over 75 have an up to 25% risk of a contrast induced acute kidney injury. In these circumstances, it is concerning that contrast media (a prescription only medicine) can be administered without a formal prescription, evidence of a careful consideration of the dose and a clearly identified responsible clinician.

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 by **30th December 2020**. 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 the following Interested Persons, the family of Mr Babbs, the Royal College of Radiologists, the CQC and to the Director of Public Health 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	06/11/2020 Signature Ms Nadia Persaud Senior Coroner **East London**