# Regulation 28: Prevention of Future Deaths report

## Gary Day (died 16.12.2020)

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| | **THIS REPORT IS BEING SENT TO:**<br><br>[redacted]<br>**Medical Director**<br>**Moorfields Eye Hospital NHS Foundation Trust**<br>**162 City Road**<br>**London**<br>**EC1V 2PD** |
| 1 | **CORONER**<br><br>I am: Edwin Buckett<br>Assistant Coroner<br>Inner North London<br>Poplar Coroner's Court<br>127 Poplar High Street<br>London E14 0AE |
| 2 | **CORONER'S LEGAL POWERS**<br><br>I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and<br>The Coroners (Investigations) Regulations 2013, regulations 28 and 29. |
| 3 | **INVESTIGATION and INQUEST**<br><br>On the 24th December, 2020 Senior Coroner Hassell began an investigation into the death of Gary Day who died aged 57, on the 16th December, 2020 at the Royal London Hospital, Whitechapel Road, London, E1.<br><br>The investigation concluded at the end of the inquest on 12th April, 2021 conducted by myself, Assistant Coroner Edwin Buckett.<br><br>I made a determination at inquest that the deceased died as a result of air embolism which was caused by an elective endoresection operation and/or associated operative treatment carried out at Moorfields Eye Hospital on the 15th December, 2020. |
| 4 | **CIRCUMSTANCES OF THE DEATH** |

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| | Gary Day has a choroidal melanoma of the left eye. After discussing his treatment options with clinicians at Moorfields Eye Hospital, he elected to have that melanoma removed by an endoresection procedure at the hospital.<br><br>On the 15th December, 2020 the operation, which took around 3 hours, was completed at about 4pm. Pressurised air was not used in the operation. Heavy oil was used as a means of attaching the retina.<br><br>Thereafter, Mr Day left the hospital at around 7.15pm, walking to a waiting taxi which took him home.<br><br>Later that evening, he became unwell. Between 9-10pm, he was taken by ambulance to the Royal London Hospital and admitted to the critical care unit.<br><br>Whilst in hospital a CT pulmonary angiogram was reviewed by a Consultant Radiologist which was suggestive of a large volume of air embolus.<br><br>Mr Day became severely unwell and died at about 10.50am on the 16th December, 2020, some 19 hours after the operation.<br><br>The post mortem examination of Mr Day concluded that his death was caused by air embolus which in turn had been caused by the endoresection operation. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows.<br><br>Evidence was given by medical staff at Moorfields Eye Hospital that:<br><br>1. Mr Day was not informed that there was any risk of death from the surgery he elected to have, even though there is a risk of air embolus, and therefore death, from this procedure. The Consent Form he signed did not make any reference to a risk of death;<br><br>2. There was no check carried out for air embolus after the operation;<br><br>3. There was confusion between medical staff as to whether or not Mr Day was to be kept in for an over-night stay in hospital. As it turned out, he was not advised to stay in hospital over-night and |

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| | was allowed to leave 3 hours after the operation had concluded. This meant that when he was taken to the Royal London Hospital on the evening of the 15th December, 2020 clinical staff in hospital did not have immediate access to any medical notes concerning his earlier procedure.<br><br>I am concerned that:<br><br>(a) Any patient who elects to have an endoresection operation of an choroidal melanoma faces a risk (however small) of air embolism and therefore death. This must be made clear to all patients undergoing such a procedure;<br><br>(b) There ought to be some check/investigation post operation to determine (or to try and determine as best possible) whether air may have entered the blood stream during the operative procedure;<br><br>(c) Patients undergoing this operation (which normally lasts between 2-3 hours) should be advised to stay in hospital as an in-patient for at least 24 hours, which would enable careful and extended monitoring of their condition and a swift and informed transfer, if necessary, to an acute care unit of a hospital in the event of a deterioration in their condition. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion, action should be taken to prevent future deaths and I believe that you and/or your organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **12th June 2021**. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the following. |

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| | • HHJ Thomas Teague QC, the Chief Coroner of England & Wales<br>• [redacted], on behalf of the family of Gary Day<br><br>I am under a duty to send the Chief Coroner a copy of your response.<br><br>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 13.4.2021 SIGNED BY ASSISTANT CORONER**<br>Edwin Buckett |