	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Mr Tim Smart, Chief Executive, King's College Hospital NHS Foundation Trust, Denmark Hill, London SE5 9RS**
1	**CORONER** I am Dr Andrew Harris, Senior Coroner, London Inner South
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.
3	**INQUEST** On 4th September 2012, I opened an inquest into the death of: **Miss Abiola Dosunmu, aged 17 years, died 24th August 2012, Case Ref: 02054-12.** It was concluded on 16th April 2014. The court found that the medical cause of death was: 1a Acute Renal Failure 1b Systemic Lupus Erythematosus
4	**CIRCUMSTANCES OF THE DEATH** The following narrative was recorded: Ms Dosonmu developed a swollen leg, a DVT being excluded at hospital on 22.02.12 and treated with antibiotics. She was found by her GP to have abnormal blood tests (ESR over 100 and CK over 6000) but when seen on 29.02.12 it does not appear these were discussed. The GP intended her to attend A&E but she did not. She is referred urgently to hospital by the GP on 07.03.12 with presumed cellulitis of her left leg, which is treated with intravenous antibiotics as an inpatient. She was found to have 3+ proteinuria but this information was not transmitted form the A&E department to clinicians on the ward before she died, who assumed with normal renal blood tests that she had normal renal function. She self discharged on 09.03.12 against medical advice, but neither the family nor GP were informed of the need to repeat her high ESR and CK. Abiola declined further tests on 23.03.12 when she had lymphadenopathy. The GP referred her to a haematologist by fax on 30.03.12, the fax not being received by the consultant. On 10.04.12 further blood tests were abnormal (ESR still 120), and Abiola was again asked to attend surgery to discuss them, but she did not. Her mother did not enquire about the results of the tests although she had a routine letter requesting she discuss them with her GP, as Abiola was getting better and she (her mother) did not understand that they were abnormal, and the doctors at the surgery and hospital did not follow up the monitoring of these. On the balance of probability the very high ESR which persisted (and proteinuria had it been known outside A&E) were signs of the underlying connective tissue disorder causing renal disease. Her symptoms settled but she rapidly deteriorated on 22nd and 23rd August with progressive swelling of her body, due to nephrotic syndrome and was found dead at home on the morning of 24th August, certified at 08.51 by the emergency services. She died from the complications of SLE. There were missed opportunities to diagnose and treat it earlier. Abiola did not comply with medical advice. The abnormal proteinuria test was not identified by those treating her in hospital. The significance of abnormal blood tests was not communicated to the family. These factors on the balance of probabilities

	more than minimally or trivially contributed to her death.
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** is as follows. – (1) The 3+ proteinuria discovered in A&E was not communicated to the ward. (2) The Trust failed to communicate the significance of the persistently raised ESR and CK to the patient and family. (3) The Trust failed to send the GP a discharge summary or communicate to the surgery the significance of the raised ESR and CK and the need for further monitoring. (4) Despite the exceptionally high ESR, elevated CK of which no cause was found and proteinuria, a diagnosis of cellulitis was preferred to that of a connective tissue disorder. The opportunity to treat her SLE was missed due to failure to diagnose the condition, whilst recognizing that diagnosis was hampered by her self discharge. (5) Before discharge neither the patient nor the imminent self discharge were not known to the consultant, who would have wished to be informed and would have sought further investigations and communications (6) Concerns (2) (3) and (5) above were not considered by the Serious Untoward Incident Investigation by the Trust. .
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Trust has the power to take such action. The Trust is asked to consider these concerns and whether, in the light of the inquest, that any, especially those it has not investigated require further 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 Friday 4th July 2014. 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 Chief Coroner and to the following Interested Persons: [redacted] (mother), [redacted] (father). I have also sent it to the Department of Health, who may find it useful or of interest. 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]** 9th May 2014 **[SIGNED BY CORONER]**