REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Mr S Bain Chief Executive East Kent Hospitals University NHS Trust Kent and Canterbury Hospital Ethelbert Road Canterbury CT2 3NG
1	**CORONER** I am Rachel Redman Senior Coroner, for the Coroner area of Central and South East Kent.
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	**INVESTIGATION and INQUEST** On 15 September 2014 I commenced an investigation into the death of Kelly Patrick WILLIS. The investigation concluded on 25 March 2015. I reached a narrative conclusion, a copy of which is attached.
4	**CIRCUMSTANCES OF THE DEATH** Kelly Patrick Willis underwent ablation for atrial fibrillation at St Thomas' Hospital on 8th October 2012. He was discharged the following day. Dr [redacted] the Consultant Cardiologist and Electrophysiologist who operated on him emailed Dr [redacted] Consultant Cardiologist at William Harvey Hospital on 10th October and advised her that if Mr Willis began to feel unwell after a period of one week that he should be contacted to exclude 'rare complications (e.g. atrial oesophageal fistula)'. Mr Willis developed symptoms of general unwellness which required him to be admitted to William Harvey Hospital on 14th October, 22nd October and 25th October. On the first and third admission it was noted on admission that he had undergone a procedure at St Thomas' Hospital who should be contacted. In spite of this documentation, it was not until Dr [redacted] reviewed the patient on 29th October that contact was made with St Thomas' Hospital. Dr [redacted] was unable to account for when she read Dr [redacted] email and the Ward Clerk, at the end of the second admission, was requested to fax a copy of the Electronic Discharge Notification to St Thomas' Hospital but failed to do so for a further seven days until 30th October. The cause of death was: 1a) Cerebral infarction 1b) Multiple septic emboli 1c) Atrio-oesophageal fistula complicating atrial ablation (08.10.12) for paroxysmal atrial fibrillation.

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 these circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. • Those caring for Mr Willis at William Harvey Hospital recognised the need to contact St Thomas' Hospital about the procedure that he had undergone there but failed to liaise with the tertiary centre before 29th October, even though this was well documented in the medical records on the first and third admissions that it should be. I am of the opinion that contact with the tertiary centre which had operated on Mr Willis should have been made when he first presented at William Harvey Hospital on 14th October, and thereafter on 22nd October and on 25th October as Dr [redacted] had requested. • Dr [redacted] did not act on the email sent to her by Dr [redacted]. Had she liaised with him it is likely, given his flu-like illness and increasing white cell count, that he would have been investigated with CT imaging either at St Thomas' Hospital or William Harvey Hospital at an earlier stage than 29th October, thus allowing the opportunity to Dr [redacted] to exclude rare complications, as he requested in his email to Dr [redacted].
6	**ACTION SHOULD BE TAKEN** • I believe that if it is documented in the medical records that action should be taken, then that request should be followed. • I consider that early contact should be made with tertiary centres which have carried out procedures or treatment in circumstances where their patient is subsequently admitted to William Harvey Hospital without a confirmed diagnosis.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th May 2015. 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: Field Fisher Waterhouse LLP Clyde & Co DAC Beachcroft 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	Signed: 30 March 2015 Rachel Redman