King's College Hospital NHS
NHS Foundation Trust

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17 August 2017

Senior Coroner Andrew Harris
Southwark Coroner's Court
1 Tennis Street
Southwark SE1 1YD

By email only

Dear Senior Coroner Harris

RESPONSE TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS: CONSTANCE CONNOLLY (DECEASED)

We write further to the above Report dated 22 June 2017 and detail the Trust's formal response below.

As a preliminary point, we note that none of the concerns raised in the Report caused or contributed to Mrs Connolly's death in light of the Conclusion reached at the Inquest hearing on 24 May 2017, namely "Natural causes contributed to by unintended consequences of necessary medical treatment". The Report in particular states that no failures of care contributed to Mrs Connolly's death.

However, there are learnings from this case, and as a Trust, we are committed to ensuring appropriate changes are implemented to continue to improve patient care.

There were two Trusts closely involved in Mrs Connolly's care prior to her death on 8 March 2016, namely our Trust and Guy's and St Thomas' NHS Foundation Trust (**"GSTT"**). Whilst we do not directly comment on the care provided by GSTT, we note relevant discrepancies in the evidence that arose during the Inquest Hearing.

Matter 1

The doctor who ordered the scan did not conduct any follow up to see that it had been performed. The Consultant chest physician said that handover of care was "dangerous time" and that it was his duty to do so.

Trust response

Mrs Connolly was planned for admission to King's College Hospital (**"the Hospital"**) following her presentation to the Emergency Department (**"ED"**) team with symptoms suggestive of a stroke. A CT head scan was undertaken, and an MRI

head scan was advised as the next step. By this stage, she was planned to be an in-patient and under the care of the Medical rather than the ED team. As such, her care was transferred to Acute Medicine and the request was submitted for an in-patient MRI scan to be performed.

Prior to the MRI scan request being processed, Mrs Connolly (with the support of her daughter) self-discharged, as both wished to continue care under the GSTT Palliative Care team who were managing her community care.

One of the junior doctors in Medicine therefore telephoned a member of the GSTT Palliative Care team that evening to update them. The junior doctor believes he spoke with the GSTT Clinical Nurse Specialist (**"CNS"**). The junior doctor was informed that the CNS was due to visit Mrs Connolly the following day with one of the Palliative Care Consultants. This visit did subsequently take place.

As Mrs Connolly had self-discharged before the MRI scan request could be processed, the request was transferred to an outpatient appointment by the Radiology staff, who noted the discharge on the patient tracking system, and Mrs Connolly was placed on the waiting list for the next available appointment. Sadly, the appointment fell on a date after Mrs Connolly had died. The Medical team communicated to the Palliative Care team, as well as Mrs Connolly and her daughter, of the importance of having an MRI scan.

The Trust agrees follow-up of patients in terms of proposed investigations is the responsibility of the team who has ordered the investigation(s). An outpatient MRI scan appointment was made, but this should have been communicated more clearly to the GP. The "virtual review", as described below under Matter 2, should facilitate clearer communication to health care colleagues, patients and families.

Matter 2

The referring doctor notified the GSTT Community Palliative Care team of the need to organise a MRI scan, on the understanding that the team was taking over care. The Consultant in the Palliative Care team explained that their role was to advise the doctor responsible for care, which was at the time, the General Practitioner.

Trust response

Given Mrs Connolly had self-discharged with an MRI scan pending and indicated (in addition to her daughter) that she wanted her care to remain under the GSTT Palliative Care team, the Trust assessed that after already communicating with the GSTT Palliative Care team, that team would now take the care forwards. This was on the basis that the GSTT Palliative Care team's role has not been explicitly clarified. It is, however, accepted that investigation and management of an MRI scan would not ordinarily be undertaken by a Palliative Care team.

It is also accepted that if a formal Discharge Notification to the GP had been completed at the time Mrs Connolly self-discharged, the GP would have been made aware of the Trust's advice for Mrs Connolly to undergo an MRI scan. Unfortunately, the Discharge Notification generated related to her presenting complaint only (for reasons explained below under Matter 3) and was not updated with the CT scan result, which raised the issue of additional investigations. Notwithstanding this, an outpatient MRI scan appointment was booked by the Trust, albeit on a date that fell after Mrs Connolly had died.

This case has highlighted the importance of clear communication on the specific roles to be played by members of healthcare teams in arranging and being responsible for follow-up investigations.

It is now possible for the Trusts and local GPs to view records of patients at GSTT and vice versa through the Local Care Record, which shows key documents and discharge summaries.

Steps have been taken to ensure that regardless of patients self-discharging, a formal Discharge Notification is always sent to a patient's GP, setting out all relevant tests/assessments performed and any follow-up arrangements if applicable. Responsibility sits with the admitting Consultant and Ward Managers, and this will be included in the junior doctors' induction information package.

Finally, as mentioned above under Matter 1, the Trust is committed to ensuring the post-take Consultant undertakes a "virtual ward round" of any patient who has self-discharged during the take period, and reassures themselves they have received appropriate follow-up by way of signposting, appointments or otherwise.

Matter 3

The discharge note to the GP from A&E indicated a diagnosis of stroke (presumed before CT scan), did not mention the CT finding of cerebral lesions that may be metastases, nor the need for EMI scan and further investigation to confirm diagnosis, nor the booking of a MRI scan.

Trust response

ED GP Discharge Notifications are generated from information populated in the ED tracking system (Symphony) with an initial 'working diagnoses' list. They are generated at 0300 hours the night after patients are seen in ED and sent in batches. Investigation results are only included automatically into GP letters from the Trust's Electronic Patient Records system once the test results are verified. With CT head scans, there is a requirement to be verified by Neuroradiology, which would have occurred the next morning.

In this case, as Mrs Connolly attended the Hospital's ED as a blue light "stroke call", she was assessed and managed as such by the Stroke team with a reasonable

working diagnosis of "CVA , cause unknown/stroke" recorded by the ED team at the time of her attendance. This explains why there was a "diagnosis" of stroke on the ED Discharge Notification.

Further, the verified CT scan report was not available when the ED GP Discharge Notification was sent and so it was not pre-populated.

The ED GP Discharge Notification states in a footnote that radiology results take 24 hours to be reported as well as the fact that the preliminary working diagnosis may change following patient admission and further investigation.

Finally, the MRI scan is not mentioned on the ED GP Discharge Notification, as this decision was made in conjunction with the admitting Medical team.

We accept this pathway can be improved and as mentioned above, the "virtual review" of all self-discharged patients will ensure we provide appropriate care to all our patients and that this is Consultant-directed.

The ongoing steps to improve the Trust's communication with patients' GPs and other healthcare colleagues are outlined below, specifically pertaining to the ED environment:

- There is currently a national recommendation from the Royal College of Emergency Medicine to improve and standardise communication from all Emergency Departments to GPs by October 2017 (the "ECDS" or Emergency Care Data Set). The ED's IT team are working to implement this and this will include a mandatory 'suspected and confirmed diagnoses' step on all ED discharge letters to GPs with details of who wrote the discharge notification and the identity of the senior clinician overseeing the patient's care.

- The Trust is developing a Trust-wide best practice guide on Discharge Notification and clinic letter writing for clinical staff, in collaboration with the local CCGs. This will include clarification that a discharge notification is required for all patients who self-discharge.

- The ED tracking system (Symphony) is planned for an upgrade, which is due by October 2017. This will enable ED GP Discharge Notifications to highlight and distinguish which investigations have been done (ideally with a result if verified), which are booked and which are still pending.

The Hospital's ED team are also due to appoint a new administrator to ensure communication and follow-up of abnormal radiology results for ED patients occurs appropriately and especially if reported as abnormal after they are discharged from ED.

Matter 4

A member of the Palliative Care team rang the A&E department and was told that the scan appointment was the next day (17th). When the patient and her daughter attended the next day, she was told that there was no appointment. Evidence was heard that the booking, which was on the basis of being an in-patient, is automatically cancelled if the patient becomes an out-patient and the clinical referral cannot be transferred to an outpatient appointment. A new referral and form needed to be completed. So the patient went home, and no further appointment was made.

Trust response

Whilst the Trust has no record of such a telephone conversation between the GSTT Palliative Care Team and any ED clinician, we recognise the importance of healthcare teams always accurately recording such conversations between teams.

At the time when the in-patient MRI scan was requested on the evening of 16 February 2016, the scan was simply classified as "pending". These requests remain as pending until assessed by the Radiology team in daytime hours. In this case, the request was placed on the waiting list for the next available appointment on 17 February 2016. It was clear to the Radiology team that Mrs Connolly was no longer an in-patient at the Trust, and as such the appointment was rescheduled as an outpatient.

We are, as described above, now setting up a "virtual review" of self-discharged patients to ensure any investigations or follow-ups can be appropriately actioned.

The Trust is committed to continually improving its services so that patient safety remains the priority. On behalf of the Trust, we would like to express our deep condolences to Mrs Connolly's family, and wish them well for the future.

Please do not hesitate to contact us should you require any clarification or further information.

Yours sincerely

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