	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: [redacted] Executive Medical Director, King's College Hospital, Denmark Hill, London SE5 9RS
1	CORONER I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	INQUEST On 19th May 2016, I opened an inquest into the death of **Constance Connolly, who died on 08.03.16 in** [redacted] It was concluded on 24th May 2017. The medical cause of death was: 1a Disseminated Nocardia Infection II Severe chronic obstructive airways disease, treated with steroids The conclusion as to the death was: Natural causes contributed to by Unintended consequences of necessary medical treatment.
4	CIRCUMSTANCES OF THE DEATH Mrs Constance Connolly died at home at 11.10 a.m. on 8th March 2016. She suffered from severe chronic obstructive airways disease from 2005 and was a smoker. She suffered a number of exacerbations often treated with antibiotics and sometimes steroids and by July 2015 was on maximal inhaler therapy. She became immuno-compromised from frailty of old age, structural damage to her lungs and prescribed steroids, acquiring the very rare infection of Nocardia which became invasive probably at about the end of January 2016. She expectorated throughout January and was given further antibiotics (without sputum analysis). Attending hospital on 16th February after a loss of speech she was found to changes in her right upper lung and to have lesions in her brain on CT scan that were considered not to be a stroke but possibly metastases. It was not possible to diagnose Nocardia from these. She was advised that other scanning including chest and brain MRI scan was needed to make a diagnosis. She declined admission and received palliative care at home.

	Follow up arrangements were not satisfactory, so that she did not have the further investigations, before she became too ill for them. Had she agreed to admission or had further investigations, diagnosis of Nocardia would still have been a difficult and high risk process and on the balance of probability appropriate treatment would not have prevented her dying from a rapidly progressive disease. Thus no failures of care contributed to her death.
5	CORONER'S CONCERNS During the course of the inquest, the evidence revealed matters in relation to discharge from A&E department, giving rise to concern that in my opinion that there is still 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 clinical decision was made that she needed further investigation on 16th February (contrast CT scan, MRI scan), that would lead to further tests to diagnose the cause of her cerebral lesions. She declined admission but was agreeable to have the investigations as an outpatient. This never happened. There are four matters in the circumstances which cause concern 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. 2. The referring doctor notified the GSTT community palliative care team of the need to organize 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. The referring doctor did not inform the general practitioner 3. The discharge note to the GP from the 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 conform diagnosis, nor the booking of a MRI scan 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 mother 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. The above evidence suggests a system failure in handover of patients who leave A&E with the need for urgent follow up.

6	**ACTION SHOULD BE TAKEN** Evidence was heard of IT links between the hospital and general practice being launched, but in my opinion, it is not clear that alone that will adequately mitigate the risk of other deaths, and KCH is in the position to consider if any further steps need to be taken. It is copied to GSTT, as the cooperation of that Trust may be necessary.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by August 17th 2017. 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 following Interested Persons: [redacted] daughter [redacted] Consultant in Palliative Care, GSTT Royal College of Emergency Medicine 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] 22/6/17 [SIGNED BY CORONER]