MISS N PERSAUD
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Respiratory Lead, NHS England, Royal Brompton Hospital, Sidney Street, London, SW3 6NB** **Email: [redacted]**
1	**CORONER** I am Nadia Persaud senior coroner, for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 5th September 2019 I commenced an investigation into the death of Kalila Elizabeth Griffiths, age 22. The investigation concluded at the end of the inquest on the 14th December 2020. The conclusion of the inquest was a narrative conclusion: *Kalila Griffiths died from natural causes. Her death was however contributed to by a lack of recognition of the seriousness of the decline of her respiratory state in the 4 weeks leading up to her death. By the 19th January 2019 Kalila required a review by a respiratory physician. Had such a review taken place, on the balance of probabilities, her death would have been avoided.*
4	**CIRCUMSTANCES OF THE DEATH** Kalila Griffiths had complex medical history including, asthma, Ehlers-Danlos syndrome

	and postural tachycardia syndrome. In December 2018 she developed shortness of breath. She attended her GP surgery on the 4th January 2019. The GP prescribed medication for a chest infection and for asthma. Despite this treatment, Kalila's respiratory health deteriorated during January 2019 rendering her largely unable to mobilise. She was confined to her bedroom for most of January 2019. Kalila required at least four attendances at her GP practice and two attendances to A & E (6 and 19 January). The second A&E attendance - 19th January 2019 - followed a life-threatening deterioration in her breathing. Kalila had recorded an oxygen saturation of 74% prior to presentation at the hospital. She had been unable to speak to the 111 operator and she could be heard with a continuous cough in the background. Notwithstanding her poor clinical state, she was discharged from hospital without the required observation; clinical assessment and history gathering. She required admission to hospital at this time, for assessment by a respiratory physician. Had she received observation in hospital and assessment by a respiratory physician on the 19th January 2019, on the balance of probabilities her death would have been avoided. Kalila passed away on the 1 February 2019. The direct cause of death was a pulmonary embolism. Her asthma was found to have contributed to her death. Her medical management on the multiple presentations over a short space of time, appears to have centred largely on treating the immediate presentation as an isolated event. Insufficient account was given to the risk of ongoing attacks and other complications arising. The Inquest heard that the general practice and the Trust involved in this case have taken a number of steps to improve the care provided to asthma patients. The Inquest however heard from a number of witnesses that there are concerns about the care provided to asthma patients nationally.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (1) Factual and expert witnesses gave evidence that there are concerns about the management of asthma patients within the NHS as a whole. The National Review of Asthma Deaths ("NRAD"), was published in 2014. This was five years before the care provided to Kalila and six years before the Inquest. Notwithstanding the length of time that has passed, the Inquest heard that eighteen of the nineteen recommendations set out in the NRAD report have not been implemented. The recommendations of importance in this case were: • Patients with asthma must be referred to a specialist asthma service if they have required more than two courses of systemic corticosteroids in the previous twelve months. • Follow-up arrangements must be made after every attendance at an emergency department or out of hours' service for an asthma attack. • Secondary care follow-up should be arranged after patients have attended the emergency department two or more times with an asthma attack in the previous twelve months. • Electronic surveillance of prescribing in primary care should be in place to pick up too many or too few preventer inhalers. (2) Clinicians raised concerns in relation to the number of different guidelines relating to asthma (NICE Guidelines, BTS/SIGN Guidelines and GINA Guidelines). It was noted that there are discrepancies between the guidelines. This makes it difficult for those general practitioners and emergency care practitioners who are providing care to patients.

	(3) It was noted that it is not clear to healthcare professionals which guidelines should be used for the management of acute asthma attacks. Many clinicians consider that the NICE guidelines can be used for the management of an acute asthma flare-up. The Inquest heard that this is incorrect and that the BTS/SIGN guidelines should be used. (4) The evidence revealed that further training is required for GPs and emergency departments in providing safe asthma care.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such 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 **17 February 2021**. 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: family of Kalila Griffiths, BHRUT NHS Trust, Fullwell Avenue Medical Practice. I have also sent it the CQC and Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**18th December 2020** **SIGNED BY CORONER**