REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Family** **2. Chief Coroner** **3. NHS England** **4. Kingston Hospital NHS Trust**
1	**CORONER** I am Lydia Brown, Acting senior coroner, for the coroner area of West 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.
3	**INVESTIGATION and INQUEST** On 22 April 2021 I commenced an investigation into the death of Angela Maguire, aged 84. The investigation concluded on 26 April 2022. The conclusion of the inquest was death due to natural causes, the medical cause of death being 1a Upper Gastrointestinal haemorrhage 1b Metastatic Cholangiocarcinoma II Ischaemic heart disease, Atrial Fibrillation
4	**CIRCUMSTANCES OF THE DEATH** Mrs Maguire became unwell and was referred to Queen Mary's hospital, London for a CT scan, performed on 31 March 2021. She then deteriorated and was taken by ambulance the following day to Kingston Hospital and admitted. Her symptoms suggested a malignancy, but this was not confirmed as the first scan was not accessed and a further CT scan was interpreted only partially. Additional tests were ongoing and clinical signs all supported the working diagnosis, so her supportive treatment was appropriate apart from a lack of senior oversight regarding her anticoagulation medication. On 7th April 2021 she began to display signs of an upper gastro-intestinal bleed, and she then deteriorated rapidly and died the following morning on 8th April in Kingston Hospital.
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. – The clinicians assisting with the inquest advised the court that there was no system to share radiology across the Region. In West London, patients are frequently transferred from hospitals to access particular specialisms of care, such as cancer care. In this case, the previous images taken at Queen Mary's Hospital, London, could not be accessed across a common link by Kingston Hospital, Surrey and therefore the opportunity was missed to see and compare previous images. While this did not have an impact on the

	outcome in this case, it could have very significant consequences and lead to missed diagnoses and potentially fatal outcomes of untreated disease processes. In this case the opportunity to offer palliative care and advise the relatives of end of life treatment was lost. The lack of a shared portal also creates further work for clinicians who have to contact the previous hospitals to access this information. There are many shared systems in place in the NHS for cross-site sharing of images and reports, and it was not clear from those assisting the court at this inquest why similar systems are not currently in place for this Region and not anticipated for "several more years".
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 1st August 2022 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, NHS England, Kingston Hospital NHS Trust 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	**1st June 2022**  **Signed by Acting Senior Coroner Mrs Lydia Brown**