	REGULATION 28 REPORTS TO PREVENT FUTURE DEATHS
1.	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2.	**CORONER'S LEGAL POWERS** I make these reports under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	**INQUEST** On 12th October 2021 an inquest into the death of Ms Katie Horne was opened. She died on 11th April 2020 in King's College Hospital, London. (case ref: 11833245) The inquest was concluded by me on 10th August 2022 with a conclusion of natural causes.
4.	**CIRCUMSTANCES OF THE DEATH** Ms Katie Horne presented to Princess Royal (PRH) A&E department in Sussex with jaundice on 1st March 2020. She was diagnosed as having hepatitis and investigated as an outpatient. Her liver function tests were monitored and deteriorated. Viral antibody test results available on 9th were not identified by doctors until the 16th when her liver function tests were: bilirubin 493 and ALT 1439 and when a gastroenterologist was first consulted. She was admitted to PRH on 18th due to concerns of incipient liver failure. Her care was reported to and monitored by Kings College Hospital liver unit (KCH) from 18th, but she was not transferred earlier as the first wave of the Covid pandemic limited the capacity of KCH to provide care. Her blood tests showed that liver biopsy was not possible at this stage and on 20th she was begun on steroids on the (correct) assumption she had auto-immune hepatitis, but she proved to be steroid resistant. She was transferred to KCH for consideration of liver transplantation on 24th. By 30th she was found to be Covid positive which according to the best international guidance at the time was a contraindication to transplantation. She developed Covid pneumonitis and died at 05.22 on 11th April.

5.	**This REPORT IS BEING SENT TO:** [redacted], Chief Executive, Princess Royal Hospital, Lewes Road, Haywards Heath, West Sussex, RH16 4EX
6.	**THE CORONER'S MATTER OF CONCERN** Despite multiple attendances as an outpatient with deteriorating hepatitis, it took 15 days for crucial blood test results to be seen by the doctors (in part due to lab backlog but there was no evidence of any doctor prioritising or chasing the results) or for a gastroenterologist to be consulted on care. This led to a liver biopsy not being possible (in part as her blood clotting had deteriorated) and later than necessary commencement of steroid therapy and consequent later referral for liver transplantion at Kings College Hospital. Although it was suggested that these failures in care were associated with the capacity of the hospital to deliver services in the first wave of the pandemic, there was little evidence to support or refute that. .
7.	**ACTION SHOULD BE TAKEN** The case is brought to the attention of the hospital as there was no internal investigation, review or action plan to see whether these problems had resolved or were systemic.
8.	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 7th October 2022. I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the case officer, [redacted] [redacted] [redacted]

9.	**COPIES and PUBLICATION** I have sent a copy of my report to the following interested persons: [redacted] (parents) [redacted], AVMA [redacted] (for Kings College Hospital), Legal Director, Hill Dickson LLP I am also copying it to Rt Hon Baroness Heather Hallett DBE, Chair of the UK Covid 19 Inquiry, noting that the ability of one hospital to perform a liver biopsy, and another to admit in a timely manner to the liver unit and to conduct transplants were all materially affected by the pandemic, quite separately from the fact that Katie acquired the virus. I am also copying this to and The Care Quality Commission, who may have interest in the matter. I am also under a duty to send the Chief Coroner a copy of your response. He 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.
10.	**[DATE]** **[SIGNED BY CORONER]** **11th August 2022** **A N G Harris, Senior Coroner**