REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, The Royal Wolverhampton NHS Trust** **2. Care Quality Commission (for information only).**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 30 May 2022, I commenced an investigation into the death of Mrs Rita Flynn. The investigation concluded at the end of the inquest on the 20 June 2022. The conclusion of the inquest was a narrative conclusion as follows: The deceased died after developing complications arising from a lung abscess. The cause of death was: 1a Right Upper Lobe Purulent Abscess (no tumour)
4	**CIRCUMSTANCES OF THE DEATH** i) Mrs Flynn was a 78-Year-old woman who contacted her GP after feeling ill with flu like symptoms. She had a telephone consultation on the 12 January 2022. ii) She was given antibiotics and also advised to take a COVID PCR test. Initially her condition improved and the COVID test was negative. iii) Subsequent Blood tests results later revealed that she had raised potassium levels and indicators for infection. She was directed to go to New Cross Hospital for further examination on 20 January 2022. iv) After further tests including x-ray and a CT scan, a differential diagnosis of malignancy or infection was made. She wasn't given any further antibiotics at this stage and effectively discharged home for further follow up treatment. v) By the 3 February 2022 her condition declined further, and she complained of shortness of breath associated with haemoptysis and was taken to New Cross Hospital by ambulance. vi) Further blood tests were taken and before the blood tests results were

	available she was discharged home on the basis she had a malignancy and didn't require immediate admission to hospital. vii) Blood tests later indicated positive signs of infection. viii) Her condition declined rapidly and sadly she passed away at home on the 4 February 2022.
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 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. – 1. Evidence emerged during the inquest that there were clear indicators of an infection and before being discharged home by the hospital, it would have been best practice to wait for the blood tests results.
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. 1. You may wish to consider reviewing your policy and guidance on discharge of patients before blood test results are known particularly where there is evidence of infection indicated. 2. In addition, where test results indicate evidence of infection and the patient has been discharged home, then consideration should be given to contacting the patient at home urgently for follow up review.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 October 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, CQC. 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	**3 August 2022**

	Mr Zafar Siddique **Senior Coroner** **Black Country Area**