REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive NHS England The Chief Executive Chelsea and Westminster Hospital [redacted], Medical Director, Chelsea and Westminster Hospital
1	**CORONER** I am Paul Rogers, HM Assistant Coroner, for the Coroner Area of Inner 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 the 30th and 31st August and 1st September 2023 evidence was heard touching the death of Kai TAKAGI. He died on 14th June 2021 aged 27 years. **Medical Cause of Death** I (a) Acute Peritonitis I (b) Perforated Gastric Ulcer **How, when, where Kai TAKAGI came by his death:** On 11th June 2021 Kai Takagi presented at Chelsea and Westminster Hospital Emergency Department with stomach ache and pain. Bloods were taken at the hospital and he was treated for gastritis and discharged home at about 2102. At 2106 shortly after discharge a blood result was received in the hospital emergency department indicating a high amylase level suggestive of acute pancreatitis. The plan was to contact Kai in the morning of 12th June 2021 with the result. This plan was handed over to the night shift and then to the morning shift doctors. Kai was not contacted by the hospital with the result as planned. No-one from the hospital asked him to return to the hospital for further examination or tests. On 14th June 2021 Kai was discovered by a work colleague at Kai's apartment [redacted] He had

	passed away in his apartment sometime between 2026 on 12th June 2021 and his discovery at 0938 on 14th June 2021" as a result of acute peritonitis from a perforated ulcer. **Conclusion of the Coroner as to the death:** Natural Causes
4	**Circumstances of the death:** Extensive evidence was heard by the court in the form of written and oral evidence, including expert evidence. Of particular significance for the purpose of this report are the following matters: (1) Kai was admitted to the Accident and Emergency Department of the Chelsea and Westminster Hospital, 369 Fulham Road, London on 11th June 2021 presenting with severe stomach pain. (2) A blood screen was ordered, and treatment commenced. (3) The treatment eased the symptoms of pain and Mr Takagi decided to leave the hospital around 2102hrs without receiving the blood result which, when received was indicative of acute pancreatitis. (4) The blood result was received shortly after Kai had left the hospital. A plan was made to call Kai back in the morning of 12th June 2021. Thereafter no-one from the hospital called him to give Kai the result or to ask him to return to the hospital which I found he would have done had he been called. (5) Kai was found dead on 14th June 2021 at his home. (6) For patients in hospital with abnormal blood results these will be captured by the medical handover and/or normal patient review or continuing care of the patient within the hospital. There is also now a book kept by the telephone in the department to record urgent abnormal results that are called through to the department from the lab. This book is checked regularly by the registrar in charge of the shift. (7) For patients that had left the hospital there was a system of call back of abnormal results to patients which depended on oral handover between shift Doctors. (8) There was a handover prompt sheet which had a small space to note those that had left and to act as a reminder to call them if a result needed to be notified to them. (9) There was safety-netting advice to advise the patient to return to hospital if their symptoms worsened. (10) It was accepted that this ring-back system was not the best. (11) I heard that some changes have already been made to the system to capture those that have left and needed to be called back with results, and further changes were being made to the system but they had not been fully implemented
5	**Matters of Concern:**

	(1) Patients that leave the hospital Accident and Emergency Department with outstanding blood results or other diagnostic tests are not followed up and "tracked" in the same way that in-patients are, thus giving rise to the risk that they are missed and urgent follow-up care is not actioned or offered. (2) That as reliance on Accident and Emergency departments for routine out of hours health care increases, the burden of call back also increases on hospitals for patients who have left at a time when their departments are already over-stretched in dealing with admissions and those presenting to the department, thus increasing the risk that patients will not be called back for urgent follow-up assessment or treatment which may be life-saving. (3) That the system remains heavily dependent on oral handover, which is not amenable to independent audit as it assumes a person has done what was asked of them. Short of an individual doctor being asked if the call back had been actioned, there is no way of checking that it has. (4) That a periodic clinician led review of all abnormal blood results (and other test results), which the hospital has explored since I raised the matter in the hearing has not been fully implemented giving rise to the risk that patients who have left the hospital with potentially life-threatening conditions suggested by the tests may not be contacted urgently asking them to return thus increasing the risk of their untimely deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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: The Family of Kai TAKAGI

	[redacted] Chelsea and Westminster Hospital The Chief Executive, Chelsea and Westminster Hospital The Chief Executive NHS England 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	**27th October 2023** **Paul Rogers** **HM Assistant Coroner Inner West London** **Inner West London Coroner's Court** **33 Tachbrook Street** **London SW1P 2ED**