REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Miss Laurinda Bower, HM Area Coroner, for the coroner area of Nottingham City and Nottinghamshire
2.	**DATE OF REPORT** 3 June 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. [redacted] Chief Executive, Nottingham University Hospitals NHS Trust and [redacted], Medical Director You are under a duty to respond to this report within 56 days of the date of this report, namely by July 29, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

6.	**SUMMARY OF CORONER'S CONCERN** **1. Ensure all ED staff are familiar with the British Thoracic Society Guidelines (advising follow up chest x-rays for patients diagnosed with community acquired pneumonia in the presence of risk factors), and ensure the discharging doctors know how to arrange the same for patients being discharged from ED** **2. A failure to have in place a system for reviewing radiology reports that arrive after the patient has been discharge from ED** **3. Poor quality discharge summaries, a failure to have in place a system for quality assurance and a failure to share summaries with patients**
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 22 July 2025, I commenced an investigation into the death of David MARRIOTT, aged 62. The investigation concluded at the end of the inquest on 03 June 2026. The conclusion of the inquest was that David died as a result of lung cancer for which opportunities for earlier diagnosis were missed.
9.	**CIRCUMSTANCES OF DEATH** David Marriott died on 18 July 2025, at City Hospital, Nottingham, as a result of metastatic lung cancer that had been diagnosed in May 2025. There were multiple missed opportunities to have arranged a follow up chest x-ray post his visit to the Emergency Department on 28 February 2024. The missed opportunities were – 1. A failure by the ED Consultant to follow the British Thoracic Society Guidelines in recording a clear plan for a repeat chest x-ray in 4 to 6 weeks, on the basis that David was in the high-risk category for malignancy, and 2. A failure by the ED department to have in place a system for reviewing radiology reports that arrive after the patient has been discharged from ED (in which the radiologist here had recommended a follow up chest x-ray as the differential of malignancy could not be ruled out) A repeat chest x-ray in 2024 probably would have led to an earlier diagnosis of his cancer. However, it is likely that David would not have been a candidate for curative treatment on account of his medical frailty, even in 2024, and therefore the outcome would ultimately have remained his sad death from this disease.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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. **Ensure all ED staff are familiar with the British Thoracic Society Guidelines (advising follow up chest x-rays for patients diagnosed with community acquired pneumonia in the presence of risk factors), and ensure the discharging doctors know how to arrange the same for patients being discharged from ED**

   NICE research cites a cancer detection rate of around 2% as a result of follow-up chest x-rays performed after a diagnosis of community acquired pneumonia (CAP).

   It is therefore imperative that all clinicians when diagnosing CAP and drafting suitable discharge plans, consider the NICE and BTS guidance with regards to follow up chest x-ray for patients with risk factors.

   NICE is clear that where the patient is in the high-risk category (as David was), the clinician ought to have a discussion with the patient about the need for and benefits of performing a follow up chest x-ray once the infection has resolved to ensure there is nothing sinister. There is no evidence this discussion was held with David.

   If a follow up chest x-ray is clinically indicated, all clinicians need to be clear on local arrangements for such. If GPs are to be asked to facilitate the booking, this must be made clear as an action for the GP on the discharge summary, within the actions section. Simply writing “GP f/u” in the notes will not suffice.

2. **A failure to have in place a system for reviewing radiology reports that arrive after the patient has been discharge from ED**

   The Emergency Department regularly arrange chest x-rays for patients. Often, the ED Consultant will review the x-ray image in order to inform their management plan, prior to the radiology report being issued. In many instances, the patient will have been discharged from ED prior to the radiology report being made available on the system. I understand this is an acceptable and reasonable practice in ED departments given the high patient footfall, the need to discharge efficiently, and the inevitable time lag between imaging and reporting of non-urgent x-rays.

   However, of significant concern, is the fact that when the radiology report arrives after the patient has been discharged from ED, the requesting clinician is not required to review the report. In fact, no-one reviews the report to see whether it contains information that should alter the management plan.

   Here, the radiologist made a clear recommendation that a follow up chest x-ray should be arranged as he could not rule out something sinister under the infection. This report ought to have been considered by the requester, or another clinician on duty, as it would have altered David’s management plan.

I am concerned that this is a long-standing issue at NUH.

In 2016, the coroner issued a prevention of future death report on this topic. The coroner was assured that the introduction of nervecentre would prevent this situation.

The SJCR in this case said, "*There is a system failing here regarding review of images [sic reports] once a patient has been discharged from ED. This is a known issue for which solutions have been proposed, including introducing a results sign off session for ED consultants utilising EDP. The current HoS has not progressed with this solution and sadly therefore, further missed imaging results are likely and similar cases of missed opportunities for intervention are guaranteed".*
It would seem, therefore, that the Trust has been aware of this risk for some time, but has failed to take action to date to seek to mitigate that risk.

I understand that NUH might be an outlier in terms of ED clinicians failing to review electronic results received post-discharge and may well be acting contrary to BMA, RCEM and NHS guidance. The BMA is clear that the ordering clinician has a duty to review test results even where the patient has been discharged (whether bloods, radiology etc) (BMA Acting on electronic test results, 2024). The BMA guidance advises that this task can be delegated within a safe system of work. I understand that many large Trusts have a named Consultant of the day who will review and file all results from the previous day. Others have an IT system that alerts the ordering clinician that the report is ready so they can simply mark it for filing or action. I am not aware of other Trusts locally that simply leave specialist reports and results unread. This is an unsafe practice, and I consider there is a clear risk of future deaths should this practice continue.

It seems to me that the duty to proactively promote patient care does not cease once the patient leaves the department. These reports are important and, in some cases, they will contain information that the ED Consultant missed when reviewing the image in a very busy and demanding environment, or could not have been aware of without reviewing the results.

3. **Poor quality discharge summaries, a failure to have in place a system for quality assurance, and a failure to share summaries with patients**

I heard evidence of a continuing concern amongst the primary care profession that ED discharge summaries often are not worth the (electronic) paper they are written on. Often, they contain inadequate or insufficient information, like the one in this case which did not make clear the steps required of the GP. Occasionally, discharge summaries do not arrive, or there can be a delay in receiving such.

	I understand the Trust does not have a quality assurance audit for discharge summaries so there is no data to underpin identification of issues and learning. I am further concerned that ED discharge summaries are not supplied to patients. If the patient is expected to act as a safeguard in proactively managing their care, they need to have the plan in writing. Placing an expectation on unwell patients to remember and recite the verbal plan for follow-up to their GP many weeks later is unrealistic. Again, ED seems to be an outlier in this regard as inpatients always receive a copy of their discharge summary and plan. The same occurs for outpatient appointments when the Consultant letter is copied to both the GP and the patient. The witnesses before me were unclear on whether ED discharge summaries appeared in the NHS patient app. Perhaps this could be clarified?
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]* • **FAMILY** • **GP** • **NUH Trust** • **NUH Medical Examiner Service** • **CQC** • **ICB** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE** **Miss Laurinda Bower** **HM Area Coroner** **Nottinghamshire**