REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Hama Medical Centre** 2. [redacted] **– Daughter of Cynthia Fretwell** 3. **Dr** [redacted] **– Area Medical Director – NHS Commissioning Board Derbyshire and Nottinghamshire** 5. **Ministry of Justice** 6. **Chief Coroner** 7. **Mr Derek Winter, HM Coroner for Sunderland (for record-keeping purposes)**
1	**CORONER** I am Jane Gillespie, Assistant Coroner, for the coroner area of Nottinghamshire.
2	**CORONER'S LEGAL POWERS** I make this report pursuant to 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 16th October 2013, I commenced an investigation into the death of Cynthia Fretwell, aged 84. The investigation concluded at the end of the inquest on 12th November 2013. The conclusion of the inquest was: On the 12th day of February 2013 Cynthia Fretwell died as a result of peritonitis as a result of an infected gall bladder which had not responded to treatment by antibiotics.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Fretwell had a history of abdominal pain and on 8th February 2013, she was admitted to the emergency department of the Queens Medical Centre in Nottingham. She had been diagnosed by her GP as having obstructive jaundice following a home visit. Upon admission Mrs Fretwell, was treated with antibiotics as the working diagnosis was of an inflamed gall bladder and localised peritonitis. Mrs Fretwell's condition improved and she was discharged on 9th February 2013 to continue a course of antibiotics in the community. On 11th February 2013, Mrs Fretwell's GP visited her at home as she was feeling unwell. It was noted that she was suffering from a temperature, tenderness in her gallbladder and jaundice. Mrs Fretwell was not admitted to hospital. On 12.02.13 Mrs Fretwell's family contacted her GP again as Mrs Fretwell was still not well. A telephone consultation took place but Mrs Fretwell was not seen in person by the GP. Mrs Fretwell remained at home and was not admitted into hospital. She died at 11.25pm that evening.
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) Telephone referrals and the lack of an effective system for conveying and responding to information between the caller and the doctor. Specifically, I had concerns about the following aspects:

	(a) The inability of reception staff to interrupt a GP during surgery for the purposes of alerting and informing the doctor of a change in the patient's condition following a telephone referral. (b) Timely consultation and timely responses to telephone referrals from patients and their families. (c) The threshold for determining whether a telephone consultation is adequate or whether a home consultation should be undertaken. (2) A full assessment of the patient's mental capacity in a situation where they are refusing medical treatment or admission to hospital. (3) Full and proper documentation of the discussions between the doctor and the patient/patient's family in those circumstances. In the course of oral evidence taken at the inquest on the 16.10.2013, I was informed of changes that had been instituted by the Hama Medical Centre since the death of Mrs Fretwell which would address these concerns. I adjourned the inquest on 16th October 2013 to provide an opportunity to the Hama Medical Centre to commit the detail of changesto writing. I asked that a report to be filed by 4pm on 30th October 2013 and the matter was re-listed on 12th November 2013. I received a report from the Hama Medical Centre dated 21st October 2013. I was satisfied from the contents of that letter and its attachments that matters 1(a) & (b) of the concerns above had been addressed. However, there was no reference to the remaining issues of concern which had been identified. In the circumstances therefore, I consider the response inadequate and feel my duty to report has been invoked.
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 10th February 2014. 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 [redacted] Mrs Fretwell's daughter and to [redacted] Medical Director for the NHS Commissioning Board in Nottinghamshire and Derbyshire. This organisation has responsibilities for overseeing primary care for patients. 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	**16.12.13** Jane Gillespie