ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Senior Partner, Fountain Medical Centre, Little Fountain Street, Morley, Leeds, LS27 9EN** **2. The Chief Executive, Leeds West Clinical Commissioning Group, Suite 2-4, Ground Floor, Wira House, Leeds, LS16 6EB** **3. [redacted]** **4. [redacted]**
1	**CORONER** I am DAVID HINCHLIFF, senior coroner, for the coroner area of West Yorkshire (Eastern)
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. [redacted]
3	**INVESTIGATION and INQUEST** On 26th November 2013 I commenced an investigation into the death of JOAN DOROTHY RICHARDSON who was then aged 33. The investigation concluded at the end of the inquest on 28th May 2014. The conclusion of the inquest was Natural Causes, the cause of death being:- 1(a) Streptococcal Toxic Shock Syndrome
4	**CIRCUMSTANCES OF THE DEATH** (1) Joan Dorothy Richardson lived with her partner, [redacted] and her 14 year old son at [redacted] (2) Ms Richardson became unwell with shivering, rapid onset of significant swelling of the whole of her right arm with bruising and discolouration of her skin. She also had swelling to her left hand. (3) Ms Richardson was taken by her partner to her GP's surgery, Fountain Medical Centre, during the early afternoon of 21st November 2013 to be told that the surgery was closed for a staff training session and that no Doctors were available. (4) An appointment was made for the following day, 22nd November 2013 and when Ms Richardson was seen by a Doctor, the Doctor was sufficiently concerned and suspected a serious infective process and advised that she should have been taken to hospital immediately. An ambulance was offered, but Ms Richardson's partner felt that he could take her to hospital more quickly in his car. (5) Shortly after entering the Emergency Department at The General Infirmary at Leeds and whilst in the waiting area Ms Richardson had a cardiac arrest and despite all efforts her resuscitation was unsuccessful and her death was

	confirmed at 15:31 hours on 22nd November 2013, the working diagnosis being a pulmonary embolus, itself a serious condition. (6) A Coroner's post mortem examination showed the cause of death to be streptococcal toxic shock syndrome, stated to be a rare condition. (7) It was the opinion of those who gave evidence at the Inquest that if Ms Richardson had entered hospital the previous day and had received relevant treatment, the outcome may have been different. (8) Delay may have been a contributory factor.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) It is correct and appropriate for GP practices to have dedicated time for staff training. (2) This should be advertised well in advance by notices in the waiting area and in the entrances to the surgery with clear and specific instructions so that patients can seek emergency treatment elsewhere. (3) On the occasions where there is a genuine emergency as there clearly was here, a Doctor should be available to deal with such an emergency notwithstanding that the surgery is closed for routine work, particularly when the training session is within normal surgery hours. (4) This is an obvious issue for the Fountain Medical Centre but should also be addressed by all GP practitioners, hence the Leeds West Clinical Commissioning Group being incorporated within this Report to ensure that all GP practices adopt the same system. In my view it would be correct and appropriate for this issue to be addressed nationally. (5) No criticism is made that a precise diagnosis was not made. Nevertheless had Ms Richardson been seen on the 21st November 2013 it would have been obvious that she was extremely unwell and that her presentation was urgent and that time was of the essence and that she should have been referred to hospital immediately. (6) The delay of almost 24 hours has been a contributory factor.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 18th August 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 the Chief Coroner and to the following Interested Persons, the Senior Partner, the Fountain Medical Centre and the Chief Executive, Leeds West Clinical Commissioning Group . I have also sent it to [redacted] (partner) and [redacted] (mother) who may find it useful or of interest. 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	**23rd June 2014** **DAVID HINCHLIFF** **Senior Coroner** **West Yorkshire (Eastern)**