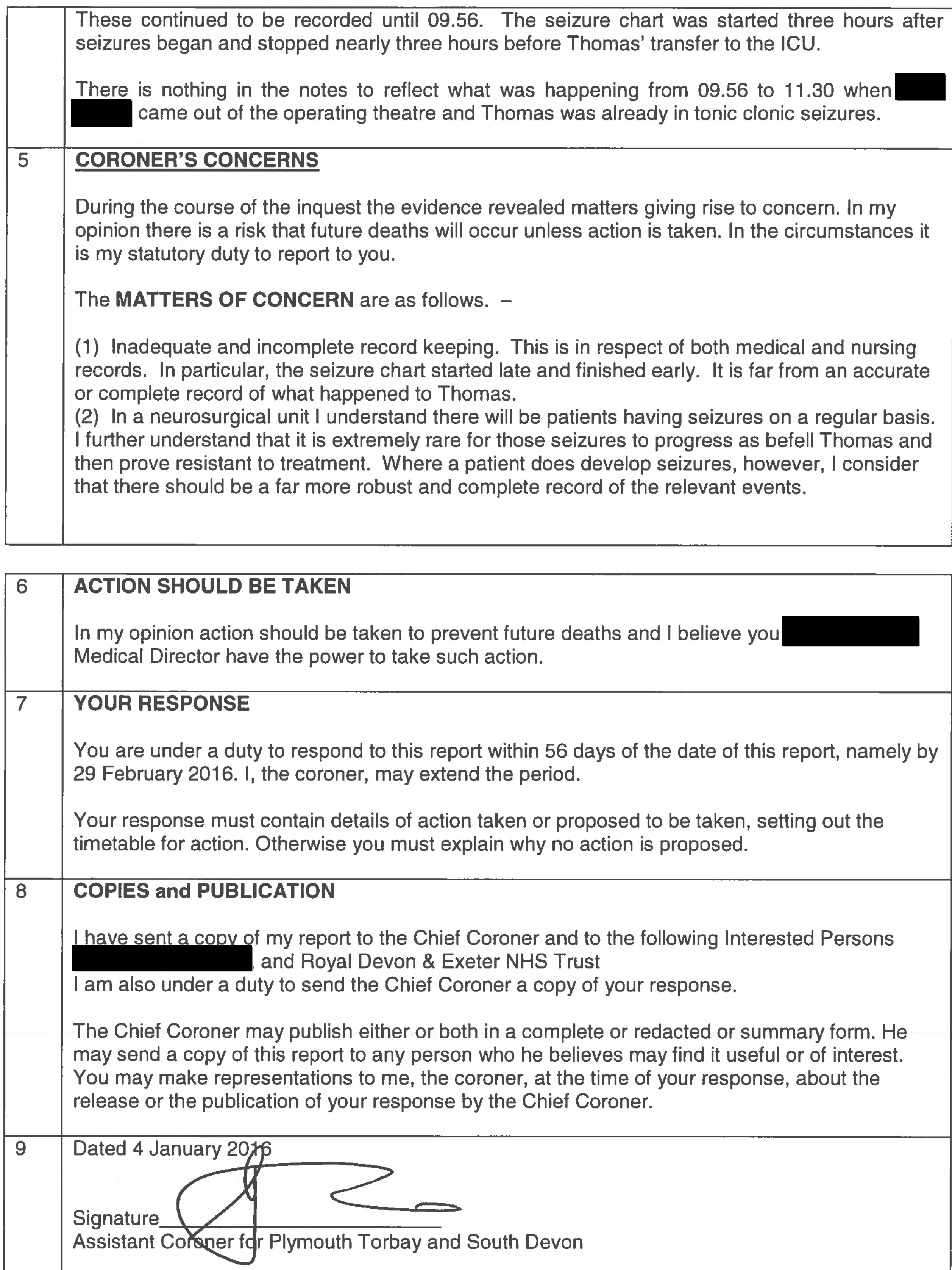
ANDREW JAMES COX
Assistant Coroner for Plymouth Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Medical Director** Plymouth Hospitals Nhs Trust Derriford Hospital, Plymouth PL6 8DH
1	**CORONER** I am ANDREW JAMES COX, Assistant Coroner for Plymouth Torbay and South Devon 1 Derriford Park. Derriford Business Park, Plymouth PL6 5DZ
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 18/07/2011 I commenced an investigation into the death of Thomas Alexander Burchell, age 22. The investigation concluded at the end of the inquest on 18 December 2015. The conclusion of the inquest was that Thomas died from Natural Causes. The medical cause of death at post mortem was given as: 1 (a) Brain Swelling and Infarction; 1 (b) Glioblastoma (WHO Grade 4)
4	**CIRCUMSTANCES OF THE DEATH** Mr Burchell's tumour was identified by CT Scan performed at the Royal Devon & Exeter Hospital on 1 July 2011. There was then a discussion with the Neurosurgical Team at Derriford Hospital and the management plan for that weekend was as follows; prescribe and administer Dexamethasone; perform an MRI to exclude a primary tumour elsewhere and discuss at the MDT on the Thursday for a definitive management plan. In the event, Thomas underwent an MRI scan at R D & E on 4 July as a consequence of which it was agreed to transfer Thomas from R D & E to Derriford that evening with a view to him undergoing a craniotomy on [redacted] list the following day. In the early hours of 5 July, however, Thomas began to develop seizures (see entry on page 150 timed 06.15). There was a discussion with the neurosurgical SPR and a loading dose of Phenytoin with an urgent CT was advised. The progression of the seizures from that point in time onwards is unclear. In her evidence [redacted] said that when she went into the operating theatre at 0900 hours she understood Thomas still to be having focal motor seizures. The entries between 06.15 and 08.50 are scant. The entry on page 152 of the notes is written retrospectively and does not indicate the time to which the entry relates. The entry at 08.50 on page 153 simply identifies that Thomas is having "seizures". It does not specify whether these are focal motor, generalised, tonic clonic or other. Similarly the entry at 09.15 does not specify the nature of the seizures that Thomas was having at that time. The seizure chart reflects the fact that at 09.15 Thomas' seizures had become generalised.



	These continued to be recorded until 09.56. The seizure chart was started three hours after seizures began and stopped nearly three hours before Thomas' transfer to the ICU. There is nothing in the notes to reflect what was happening from 09.56 to 11.30 when came out of the operating theatre and Thomas was already in tonic clonic seizures.
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) Inadequate and incomplete record keeping. This is in respect of both medical and nursing records. In particular, the seizure chart started late and finished early. It is far from an accurate or complete record of what happened to Thomas. (2) In a neurosurgical unit I understand there will be patients having seizures on a regular basis. I further understand that it is extremely rare for those seizures to progress as befell Thomas and then prove resistant to treatment. Where a patient does develop seizures, however, I consider that there should be a far more robust and complete record of the relevant events.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Medical Director 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 29 February 2016. 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 and Royal Devon & Exeter NHS Trust 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	Dated 4 January 2016 Signature________________________ Assistant Coroner for Plymouth Torbay and South Devon

3 The Crescent, Plymouth, PL1 3AB
Tel 01752 204 636 | Fax 01752 313297

ANDREW JAMES COX
Assistant Coroner for Plymouth Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Senior Partner The Borchardt Medical Centre, 62 Whitchurch Road, Withington, Manchester M20 1EB**
1	**CORONER** I am ANDREW JAMES COX, Assistant Coroner for Plymouth Torbay and South Devon, I Derriford Park, Derriford Business Park, Plymouth PL6 5DZ
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
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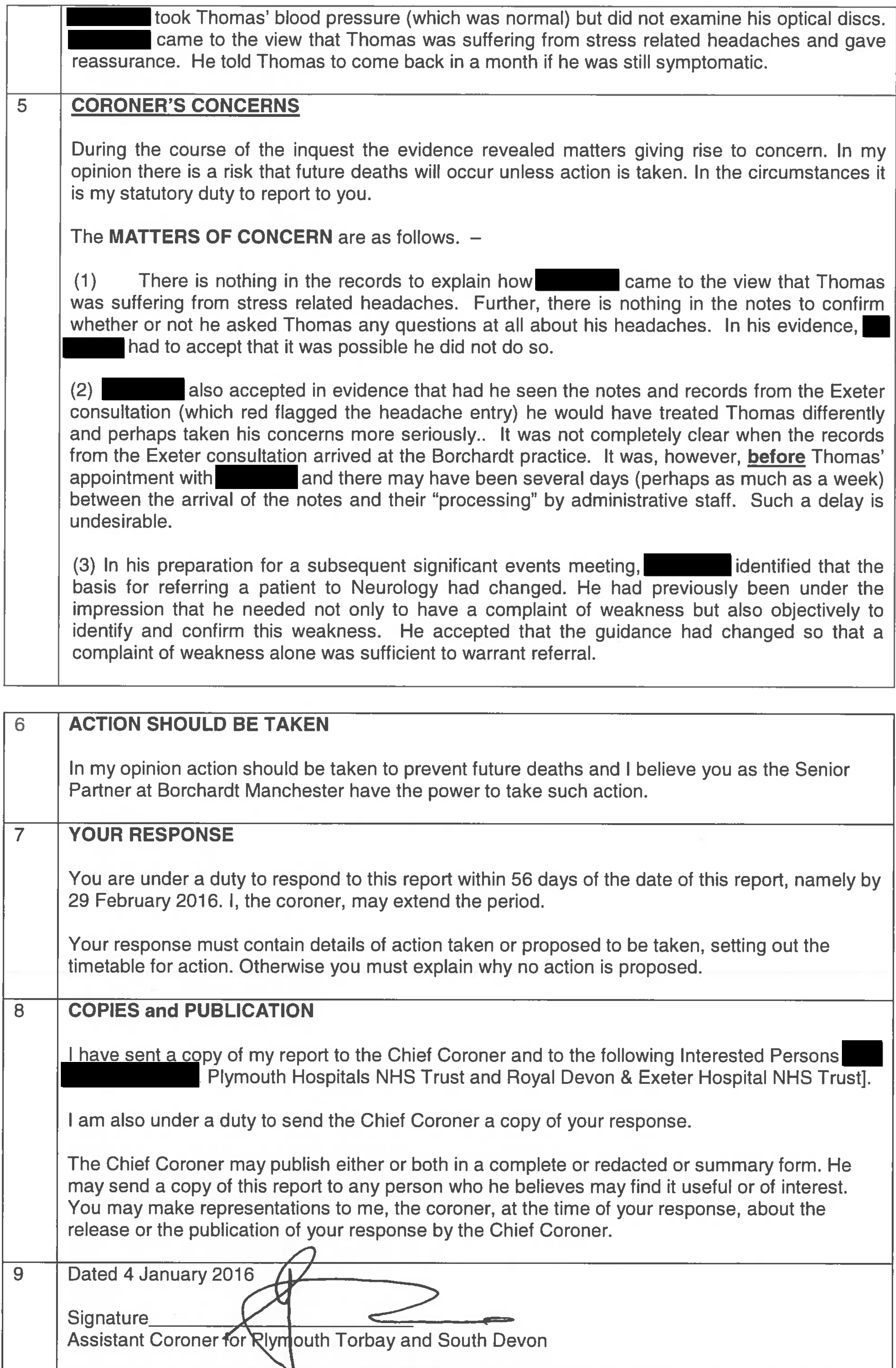
4	**CIRCUMSTANCES OF THE DEATH** Mr Burchell was in his final at University. At around Easter 2011 he complained to his mother that he was not feeling well and suffering with vague and intermittent symptoms. On 21 April 2011 Thomas saw a GP in Exeter. He was complaining of intermittent headaches, worse in the morning, as well as difficulty getting up in the morning. He reported no visual changes but some nausea. The GP performed a thorough physical and neurological examination which revealed nothing of note. She took some bloods. As Mr Burchell was returning to college in Manchester, she posted the results of the blood tests to Thomas' mother with his consent. On 11 May 2011 Thomas registered with your practice. On 9 June he saw [redacted] She understood the issue to be a raised liver enzyme (revealed from the blood test) and the fact that Thomas felt tired all the time. She was not able to explain his fatigue and so reached no diagnosis. She took more bloods for testing to see whether he was anaemic, or whether there were any issues with kidney or thyroid function. She also wanted to look at his inflammatory markers. On 22 June 2011 Thomas saw [redacted] In his evidence [redacted] accepted that by that time the medical notes and records of his appointment with the GP in Exeter were in the surgery. [redacted] said that he could have looked at these if he felt it was necessary to do so but he did not. I attach a copy of the computer entry made in the notes and records relevant to this consultation. It is evident [redacted] was told Thomas had frontal bilateral headaches with nausea and a weakness on his left side.



████ took Thomas' blood pressure (which was normal) but did not examine his optical discs. ████ came to the view that Thomas was suffering from stress related headaches and gave reassurance. He told Thomas to come back in a month if he was still symptomatic.

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) There is nothing in the records to explain how ████ came to the view that Thomas was suffering from stress related headaches. Further, there is nothing in the notes to confirm whether or not he asked Thomas any questions at all about his headaches. In his evidence, ████ had to accept that it was possible he did not do so.

(2) ████ also accepted in evidence that had he seen the notes and records from the Exeter consultation (which red flagged the headache entry) he would have treated Thomas differently and perhaps taken his concerns more seriously.. It was not completely clear when the records from the Exeter consultation arrived at the Borchardt practice. It was, however, **before** Thomas' appointment with ████ and there may have been several days (perhaps as much as a week) between the arrival of the notes and their "processing" by administrative staff. Such a delay is undesirable.

(3) In his preparation for a subsequent significant events meeting, ████ identified that the basis for referring a patient to Neurology had changed. He had previously been under the impression that he needed not only to have a complaint of weakness but also objectively to identify and confirm this weakness. He accepted that the guidance had changed so that a complaint of weakness alone was sufficient to warrant referral.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you as the Senior Partner at Borchardt Manchester 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 29 February 2016. 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 ████ Plymouth Hospitals NHS Trust and Royal Devon & Exeter Hospital NHS Trust].

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 Dated 4 January 2016

Signature__________________________
Assistant Coroner for Plymouth Torbay and South Devon

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