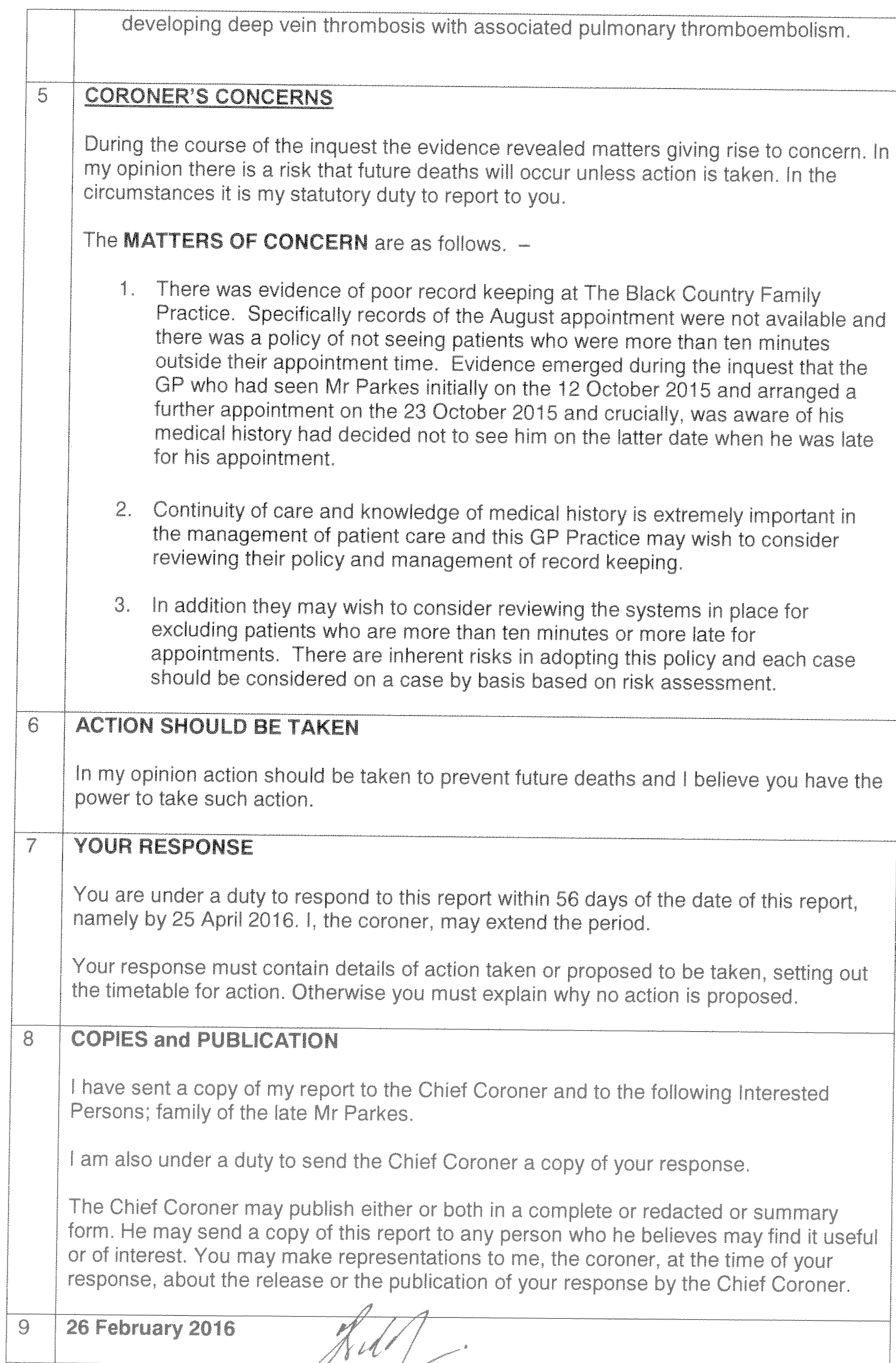
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. **Practice Manager, The Black Country Family Practice, Neptune Health Park, Sedgley Road, West Tipton, West Midlands, DY4 8PX** 2. **Family of the late Mr Parkes**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 28 December 2015, I commenced an investigation into the death of Mr Richard Parkes. The investigation concluded at the end of the inquest on 24 February 2016. The conclusion of the inquest was the deceased died by way of natural causes on the 28 December 2015 from: 1a. Pulmonary Infarction 1b. Bilateral Pulmonary Thromboembolism 1c. Deep vein Thrombosis
4	**CIRCUMSTANCES OF THE DEATH** 1. During the course of the inquest I heard evidence that Mr Parkes had returned to England after a driving trip to Europe on the 31 July 2015. Shortly afterwards, he began to complain of pain in his left lower calf and was seen by a Doctor at a Walk in Centre on 8 August 2015. This Doctor diagnosed musculoskeletal leg pain after examining him and recorded that there was no calf swelling or tenderness. He was subsequently given analgesia for pain relief. 2. This was followed by a visit to his General Practitioner at his normal GP surgery on the 1st October 2015. He was examined and a full medical history taken and recorded that there were no symptoms of swelling in his calf, chest pain or shortness of breath described. He was diagnosed with superficial thrombophlebitis and given naproxen and inflammatory cream. 3. He was seen again on the 12 October 2015 by a GP at the same surgery and the same diagnosis made. Deep Vein Thrombosis (DVT) was considered as a differential diagnosis but was dismissed because there were no other symptoms of DVT including shortness of breath and significant swelling to the calf area. He subsequently returned to the surgery again on the 23 October but wasn't seen due to being late. 4. A further appointment was made on the 4 November 2015, and he was examined again. The Doctor recorded that there were no symptoms of DVT described. After this appointment he continued to work and travel as normal but wasn't seen by another Doctor until he collapsed on the 28 December 2015 and passed away from



	developing deep vein thrombosis with associated pulmonary thromboembolism.
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 was evidence of poor record keeping at The Black Country Family Practice. Specifically records of the August appointment were not available and there was a policy of not seeing patients who were more than ten minutes outside their appointment time. Evidence emerged during the inquest that the GP who had seen Mr Parkes initially on the 12 October 2015 and arranged a further appointment on the 23 October 2015 and crucially, was aware of his medical history had decided not to see him on the latter date when he was late for his appointment. 2. Continuity of care and knowledge of medical history is extremely important in the management of patient care and this GP Practice may wish to consider reviewing their policy and management of record keeping. 3. In addition they may wish to consider reviewing the systems in place for excluding patients who are more than ten minutes or more late for appointments. There are inherent risks in adopting this policy and each case should be considered on a case by basis based on risk assessment.
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 25 April 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; family of the late Mr Parkes. 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	**26 February 2016**