REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Officer, Bury Clinical Commissioning Group, Bury, Greater Manchester
1	**CORONER** I am Ms L Hashmi, Area Coroner for the Coroner area of Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 14th September 2016 I commenced an investigation into the death of **Elaine Talbot.**
4	**CIRCUMSTANCES OF DEATH** The deceased had been under the care and supervision of her general practice for approximately 3 weeks prior to her death, with a history of sudden onset of headaches, nausea and vomiting. She was initially diagnosed as suffering from migraines based on her symptomology and family history. Repeat telephone and face to face consultations took place and treatment was subsequently altered and/or increased. Whilst there was some improvement, medication did not completely remedy the signs and symptoms with which the deceased presented. Having called an ambulance on the 31st August 2016, the deceased was conveyed to the local hospital's Emergency Room. Her presenting condition was persistent headache and nausea. The doctors were aware of the fact that the deceased had been under the care of her GP and that a diagnosis of migraine had been made. A CT Scan was not considered or directed. Had a CT scan been carried out on that date then, more likely than not, the tumour subsequently identified would have been seen and arrangements made for the deceased to be admitted to hospital. On this occasion, the deceased was diagnosed with and treated for ongoing symptoms of migraine and discharged home the same day with further medication and advice. The deceased's condition continued to deteriorate and she re-presented to the Emergency Room by ambulance on the 7th September 2016, extremely unwell. On admission, she was assessed by the Stroke team and a CT scan was directed as her level of consciousness was very low. Medical care and treatment was instigated in a timely manner. The CT scan showed a large mass in the frontotemporal parietal region of the deceased's brain. Following admission and in spite of treatment, the deceased suffered a cardiac arrest. She died at Fairfield General Hospital the same day. The cause of death following neuropathology post mortem examination was: 1a) Cerebellar coning 1b) Right frontal glioblastoma **Narrative conclusion**: Natural causes, to which a number of missed opportunities to investigate and escalate may have had a material bearing on the timeliness of diagnosis, treatment and intervention for the presence of the brain tumour eventually identified. Whilst the thrust of the evidence disclosed gross failure to provide basic care to the deceased who by virtue of her condition was in a dependent position, it was not possible on the evidence heard to establish a causal link between such failure/s and the direct cause of death, to the required legal standard.

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. During the course of the evidence heard at inquest, the deceased's GP explained that he had no ability to make a direct urgent referral for urgent CT scanning– unlike other GPs in neighbouring towns. He considered that such accessibility would be beneficial. Whilst it is unlikely that earlier scanning in Mrs Talbot's case would have materially altered the very sad outcome, I am concerned that the lack of urgent direct access to CT scanning by clinicians working in primary care may potentially have a bearing upon the outcome for others in terms of prevention of future deaths. This appears to be a commissioning issue and that is why I am directing this PFD form to you. I Further, your letter of the 7th April 2017 did not address the issue sufficiently.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 16:30 on the 14th June 2017. 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 namely:- - The deceased's family - Department of Health, London - NHS England - The deceased's GP - Pennine Acute Hospitals 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 from. 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	Date: 19th April 2017 Signed: