REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Senior Partner, Stonefield Street Surgery, Rochdale
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 20th October 2015 I commenced an investigation into the death of **Sarah Kiff.** This investigation was concluded by way of inquest on the 20th November 2017.
4	**CIRCUMSTANCES OF DEATH** In January 2013 the deceased presented to her General Practice with a vaginal discharge. Antibiotic treatment was instigated. She re-attended end January 2013 with urinary symptoms and was seen by a different doctor who instigated further antibiotic therapy. A swab was directed and a urine sample was sent for testing. On the 8th February the deceased re-attended the practice and was seen by a third doctor. On this occasion she presented with a history of heavy menstruation for the past 6 months, ongoing lower abdominal pain and vaginal discharge. A full gynaecological history was not taken, a gynaecological examination was not conducted nor were arrangements made for the same to be carried out at another time. Such an examination was necessary so as to ensure no obvious abnormalities and in order to visualise the cervix. Further antibiotics were prescribed and an ultrasound scan requested. The scan ultimately proved negative but would not, in any event, have shown any disease process within the cervix. The deceased was not referred to a gynaecologist for further testing or opinion. On the 22nd February the deceased was seen by a locum GP who further prescribed topical antibiotics. Again, a full gynaecological history was not taken and a gynaecological examination not conducted in order to check for abnormalities. The doctor had been falsely reassured by the ultrasound scan result, the result of which was conveyed to him by the patient rather than by way of formal reporting at the time. On the 11th July 2013 the deceased presented with ongoing urinary symptoms. Antibiotics were prescribed and a swab directed. On the 18th July, she was seen by another doctor who made an urgent referral to a gynaecologist. Following colposcopy and biopsy, a diagnosis of squamous cell carcinoma of the cervix (6 cm) was made. Subsequent scans identified liver metastases. This was an unusual presentation of metastatic disease. It was not possible to operate upon the deceased nor to cure her condition by this stage however treatment was afforded in the form of chemotherapy and radiotherapy. Initially the deceased made good progress however by May 2015 further physiological complications arose. Treatment and general decline took their toll. On the 14th October 2015 the deceased was seen by the out of hours GP, following the result of a low blood count. She was admitted to Accident and Emergency. Shortly thereafter, she suffered a cardiac arrest. A cycle of advanced life support/CPR was carried out before the decision was made to discontinue. The deceased died at Fairfield General Hospital later the same day. NICE guidance had not been followed and communication as to the GP/s requirement regarding vaginal examination by the Practice

	Nurse not specifically conveyed. Whilst the evidence disclosed gross failures to provide basic medical care, on a cumulative basis, causation could not be established to the required legal standard of proof. Though chemotherapy contributed to the deceased's decline, the direct cause of her death was the normal progression of a natural illness having run its full course. It was not possible to say, on the evidence heard, whether earlier diagnosis and intervention would have materially altered the outcome. I reached a conclusion of natural causes.
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. GPs at the Practice did not follow the NICE 2005 cancer referral guidance. This puts patients at risk. 2. Medical record keeping and communication between the medical and nursing teams was poor. The doctor/s were not explicit about what they required the nurse to do in terms of P.V. examination and made assumption that the nurse/s knew what the doctors expected of them. 3. There was lack of continuity of care and a failure by doctors to fully appraise themselves of the clinical history ahead of consultation. The care provided to Ms Kiff was, on occasions, perfunctory. 4. During the course of the evidence it became apparent that male doctors were reluctant to carry out internal examinations on female patients as they felt it more appropriate for their female colleagues to do them. Reluctance was not related to patient preference (in this case the patient was not offered any such examination). Moreover they felt that female doctors were, skill wise, more able. 5. The processes and procedures in place for reviewing test results and ensuring that they appear within the patient's electronic records appears to be inadequate.
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 the 15th January 2018. 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 • MDU acting on behalf of [redacted] Locum GP) • Rochdale CCG • CQC 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: 20th November 2018 Signed: