REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **This report is being sent to:** The Director, Cancer Alliance, SYBND, 722 Prince of Wales Road, Sheffield, S9 4EU
1	**CORONER** Professor Christopher P Dorries OBE, HM Senior Coroner for South Yorkshire (West)
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** On the 5th July 2017 I commenced an investigation into the death of Mrs Pamela Sunter (aged 69). The investigation concluded at the end of the inquest on 14th February 2019. The narrative conclusion of the inquest was that: *Mrs Sunter died on the 1st July 2017 in the Northern General Hospital, Sheffield. It is likely that since May she had been developing a rare infection which progressed eventually to two abdominal aortic aneurysms arising from an aortitis. Whilst it is recognised that this condition is exceedingly rare and that reaching a diagnosis earlier would have bene immensely difficult, there was an opportunity lost to progress the matter when cultures were not taken from Mrs Sunter at an early stage of her admission to the hospital at Barnsley on the 14th June 2017. However, it cannot be said that different actions would more likely than not have saved Mrs Sunter's life.* The issue of this Regulation 28 Report does not relate to the matters recorded in the narrative conclusion but rather to a possible issue of confusion between an urgent referral for an ultrasound scan and a referral for a two week wait consultant appointment.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances so far as relevant to this Regulation 28 report are as follows. A General Practitioner saw Mrs Sunter on the 26th May 2017. The complaint was of low back pain for some weeks, significant weight loss and a bloated/tender abdomen. The doctor arranged for blood tests and an urgent direct access ultrasound. There seemed to be much confusion around this point but the inquest clarified the situation. This was a referral to have the scan done promptly, not to see a clinician. Had the scan revealed a need, then a further two week referral to a clinician would have been required.

	Discussion subsequent to the inquest has indicated that the potential source of confusion for two week wait forms in this case has very likely been overtaken by the provision of redeveloped forms already. However, I have learnt that whilst it is relatively easy to place new forms on a system it is apparently much more difficult to remove old forms which can sometimes lead to a confusion. Further confusion could obviously endanger the life of a patient.
5	**CORONER'S CONCERN** During the course of the investigation my inquiries revealed matters giving rise to a 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** may be briefly summarised as follows -- a) The removal of two week wait forms that are no longer to be used might be given as much priority as the placing on the system of new forms. Too many old forms on the system could lead to an unnecessary confusion.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, Cancer Alliance have the power to take such action forward.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th May 2019. I may extend this period upon request. 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, the family of Mrs Sunter, the General Practitioner and the Trust Solicitor, Barnsley District General Hospital. I have also sent it to the following who may find it useful or of interest; the Care Quality Commission. 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.

Professor Christopher P Dorries OBE

20th March 2019