REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) The Right Honourable Jeremy Hunt, Secretary of State, Department of Health, Richmond House, 79 Whitehall, London.**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner North London
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** Marina Fagan died on 6 October 2015, aged 50 years, from a rare but severe neurological disorder, Posterior Reversible Encephalopathy Syndrome/Reversible Cerebral Vasoconstriction Syndrome (hereafter PRES). An inquest into her death was heard on 22 April 2016, at which I recorded a conclusion of natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Ms Fagan was admitted to hospital on 17 September 2015, suffering with a headache. She was discharged on 19 September after investigations ruled out a subarachnoid haemorrhage. On that day she reattended the Accident and Emergency department of the same hospital suffering from headache and was discharged after a neurological examination showed no abnormalities. A recommendation was made to her GP to refer her to neurology outpatients. This referral was undertaken on 24 September but Ms Fagan reattended hospital on 25 September with further headache symptoms. She became confused on 26 September but it was not until 29 September that a clinical review demonstrated the presence of visual loss and eye movement palsy. An MRI was undertaken on 30 September, which demonsrated PRES; transfer to a tertiary care hospital occurred. Despite supportive treatment Ms Fagan died from PRES on 6 October 2015.
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) I heard evidence from the neurologist who treated Ms Fagan that, had the headache been persisting on 19 September (which was unclear from the evidence), then he would have expected to be involved in her care. He went on to state that an MRI would have been requested on that day. He also set out his expectation that neurology input should have been initiated after Ms Fagan developed confusion on 26 September, at which point an MRI would also have been requested. However, it was clear from his evidence that, even had PRES been diagnosed earlier, it would not have been treatable, given the severity of the condition. This witness set out his concern that, nationwide, there are insuffient neurologists to provide necessary specialist care. He noted that in the out of hours setting, although there were neurologists available the nearby tertiary care hospital, none were on-call in the hospital to which Ms Fagan was initially admitted. Ms Fagan's general practitioner set out that the current waiting time to see a neurologist in the outpatient setting, is 72 days. Given the issues regarding availability of specialist neurological care, I am concerned that future deaths will occur in similar circumstances.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressee, has 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 17 June 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, Ms Fagan's family and Barts Health 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	**22 April 2016** **Assistant Coroner R Brittain**