REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Eden Park Surgery, c/o MDU Legal Dept, 1 Canada Sq, London E14 5GS**
1	**CORONER** I am assistant coroner for the coroner area of Inner London South
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 12 September 2017 I commenced an investigation into the death of Nigel Handscomb, age 65. The investigation concluded at the end of the inquest on 27 July 2018. The conclusion of the inquest was: Medical cause of death: 1a) Aspiration pneumonia 1b) Bronchopneumonia II Severe ketoacidosis Conclusion Natural causes to which neglect contributed
4	**CIRCUMSTANCES OF THE DEATH** Mr Handscomb was seen by you at the GP surgery on 18 August 2017. Later that day he was admitted to University Hospital Lewisham (UHL). He was found to have pneumonia and possibly to have suffered a stroke. At UHL he was not reviewed by a doctor for 48 hours and opportunities to escalate his care were missed. Mr Handscomb suffered a cardiac arrest and died on 21 August 2018.
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. – During your evidence to the inquest it became clear that the notes you had made of your consultation with Mr Handscomb were incomplete and inaccurate. Although in this case I accepted that this did not cause or contribute to the death I am concerned that, if repeated, it may do so in other cases. The inquest was told that GP records will now be more readily available to hospitals and will therefore inform their decision making processes. (1) Your records were made several hours after the consultation. (2) You did not record that you had carried out a chest examination, or the result of

	this examination. (3) You did not record that Mr Handscomb had told you that he had not taken his lithium medication for several days. This was of particular importance in view of the possibility that his symptoms might be the result of lithium toxicity. (4) You did not record that you carried out a swallow test and that Mr Handscomb could not swallow. (5) You prescribed medication and recorded that it should be taken once a day in the morning. This was the instruction recorded on the medication packet. Your evidence was that you told Mr Handscomb to take the medication that afternoon. This was not recorded.
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 27 September 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: (1) Mr Handscomb's family (2) University Hospital Lewisham 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	**1 August 2018** **Philip Barlow**