ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Leeds Teaching Hospitals NHS Trust** **2. Calderdale and Huddersfield NHS Trust**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire East.
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 23rd March 2018, an investigation was commenced into the death of Sharon Jamela Reeve, aged 46. The investigation concluded at the end of the Inquest on 18th October 2019.
4	**CIRCUMSTANCES OF THE DEATH** Sharon Jamela Reeve developed a persistent headache in February 2018 which endured for several weeks. She attended her GP three times and hospital twice that month in search of treatment. On 1st March 2018, following a consultation with a consultant neurologist, she also underwent CT and MRI investigations which were reported on by two consultant radiologists at a district general hospital. The abnormal appearance of the scans prompted the radiologists to advise she should be admitted and a neurosurgical opinion obtained before treatment was initiated. Incomplete information was electronically supplied to a tertiary neurosurgical unit at a teaching hospital. A locum registrar responded 'nil neurosurgical intervention' and indicated an urgent neurologist's referral was needed. The same day, anticoagulant therapy was commenced and she was discharged from hospital. On 10th March 2018, she was found in an unresponsive condition and admitted to intensive care. Despite emergency surgery, she did not recover and died on 14th March 2018 at 17:25 hours at Leeds General Infirmary.
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) The two consultant radiologists at the district general hospital saw a need for a

specialist opinion to assist in the interpretation of complex and abnormal CT and MRI scans. There was no clear prescribed pathway for them to obtain direct access to neuroradiologists at the tertiary centre. In consequence, an inapposite referral was made to a neurosurgical unit, which did not assist the resolution of the uncertainties regarding the correct diagnosis. My concern is that if much needed linkages between relevant groups are not appreciated and made effective, then the value of having a specialist resource could be lost in future cases, not only in the medical specialty and hospital involved here, but in many others as well.

(2) Communications between the clinicians at the district general hospital ('DGH') and the tertiary neurosurgical unit were suboptimal. The interaction between them on this occasion yielded no benefit and caused valuable time to be lost. Had the communication been effective, it is likely the patient's condition would have been identified and treatment provided which would probably have saved her life.

The pertinent features of the miscommunication were:

1. Routing the referral sought by radiologists via the treating clinicians rather than direct from the radiologists. This led to incomplete information accompanying the electronic referral (specifically no copies of the CT and MRI reports produced by the radiologists).
2. It was not clear what input the clinicians were seeking from the neurosurgeons. No clear questions were posed.
3. The CT and MRI images were sent by the DGH, but via a slow conduit, with the result that the locum registrar dealing with the referral did not see them.
4. The recipient to the referral at the neurosurgery unit did not probe for further information before responding, even though he was informed that the images had been "linked". The locum registrar did not endeavour to elucidate what questions were being asked in the referral. There appears to be a lack of firm rules for clinicians in neurosurgery as to whether they must review images before responding.
5. It was apparent from the evidence taken at the Inquest that the two consultant radiologists at the DGH would have been aided by a discussion with a neuroradiologist at the tertiary centre. Instead of puzzling over whether the abnormality should be attributed to a clot or a bleed on the brain, this may have helped identify a diagnosis of hydrocephalous – as was done by the two consultant neurosurgeons who gave evidence at the Inquest in respect of their review of the images.

(3) Evidence was heard at the Inquest to the effect that numerous inappropriate referrals are made to the tertiary neurosurgical unit. I am concerned that this may be due to a lack of clarity at the entrance to the electronic portal so as to: -

(a) Make plain the circumstances in which it should be used – and where it is not appropriate.

(b) The information required to be included.

(c) The precise issues upon which guidance is sought.

If relatively junior clinicians are likely to be involved in the interface between DGH and tertiary specialist centres, there may well be a training component to improve the quality of information and requests submitted.

It was said that the electronic referral system in use at Leeds General Infirmary Neurosurgical Unit in March 2018 has been replaced. As the Inquest was not provided with details of the replacement system, the court was not able to consider whether the concerns outlined here have been resolved.

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 23rd December 2019. 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 who may find it useful or of interest: • [redacted] (daughter) • [redacted] (son) • [redacted] (GP at The Grange Group Practice, Fartown Grange, Spaines Road, Huddersfield, HD2 2QA). I have also sent it to The West Yorkshire Association of Acute Trusts (at WYAAT PMO, Trust HQ, St James's University Hospital, Beckett Street, Leeds, LS9 7TF) 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	**21st October 2019**