ANDREW JAMES COX
Assistant Coroner for Plymouth Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Jeremy Hunt MP Secretary of State for Health and CQC, Safeguarding team, National Customer Service Centre, Citygate, Gallowgate, Newcastle-Upon-Tyne NE1 4PA**
1	**CORONER** I am ANDREW JAMES COX, Assistant Coroner for Plymouth Torbay and South Devon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 29 September 2015 I commenced an investigation into the death of Roy Gordon Millar aged 62. The investigation concluded at the end of an inquest on 12 September 2016. The conclusion of the inquest was that Mr Millar died from Natural Causes. The medical cause of death was given as 1 (a) Seizure and Brain Swelling; 1 (b) Glioblastoma
4	**CIRCUMSTANCES OF THE DEATH** Mr Millar attended the A & E Department of Plymouth Hospitals NHS Trust (PHNT) on 8 February presenting with slurred speech and right facial droop. He had a CT Scan. At a Ward round on 9 February an MRI Scan was requested. Review of both scans revealed a subtle area of abnormality on the right temporal lobe of Mr Millar's brain. The Consultant requested that a further MRI scan with contrast be performed in 4 weeks time with a medical review in 8 weeks time. The repeat MRI scan was performed on 8 March 2015. Unfortunately the results of the scan were not sent to the correct Consultant with the consequence that a recommendation for a further scan in 3 months time was not followed up. The Out-Patient appointment the Consultant requested in 8 weeks from the February admission was not put into being. This was due to reasons that are explained further below. On 10 August 2015 Mr Millar re-presented to PHNT with more severe facial droop. A tumour was identified. After review by a Neurosurgeon it was arranged for Mr Millar to undergo a biopsy and debulking procedure. Unfortunately Mr Millar died on the date fixed for the operation being 25 August 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. – PHNT instigated a Root Cause Analysis following this incident, a copy of which is enclosed. [redacted] the author of the Report and the Trust's Patient Safety Lead, attended the Inquest. During the course of the hearing it emerged that the Ward Administrator in the Neurology Department had been recently appointed. She had been trained by her predecessor. Neither the previous nor the current Ward Administrator were aware of their responsibility to book follow-up appointments for patients who had been discharged. Their understanding was that appointments would be arranged by Consultants' secretaries and it seems apparent that a large number of appointments were made in this way.

1 Derriford Park, Derriford Business Park, Plymouth, PL6 5QZ
Tel 01752 204636 | Fax

	il emerged during the course of the Inquest that the Ward Administrators in the Neurology Department had not booked follow-up appointments for approximately 26 months. As you will see from the enclosed Root Cause Analysis, PHNT has reviewed 1000 patient admissions and it has revealed that 146 patients die not have follow-up appointments booked. In Mr Millar's case the evidence I heard was that had the follow-up scan been conducted in June 2015 this was likely to have led to a biopsy which would have diagnosed the brain tumour. If Mr Millar had undergone earlier surgery, the Inquest heard that he would have had a 50% chance of surviving for a year.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as the Secretary of State for Health have the power to take such action. The Inquest heard of the changes that have been made within PHNT. Ward Administrators now receive formal training when appointed. A formal Ward Clerk Training Manual has been produced. A regular Ward Clerk Forum has been set up that meets monthly. The relevant administrative practice note (APN) of which the former and current Ward Administrators were unaware has been re-circulated on three occasions. I was satisfied at the conclusion of the Inquest that there were no additional steps the Trust could reasonably be expected to take to prevent similar fatalities in the future. I was concerned, however, that the difficulty revealed by this investigation could easily be happening in other Trusts across the Country. It is for this reason that I write to you in order that the learning that has come out of this Inquest can be shared nationally if you feel that to be appropriate. I am further copying this letter to the Care Quality Commission who, as you will know, are tasked with the inspection of Hospitals. The difficulties that occurred with the fixing of Out-Patient appointments in the Neurology Department were not picked up by CQC as I suspect their inspections simply were not intended to detect such a problem. In bringing this issue to the attention of the CQC I hope this will allow consideration to be given to whether this is an appropriate additional matter for CQC to inspect.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 08 November 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 and to the family of Mr Millar. 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. I have also written formally to the Chief Executive at PHNT asking for details of the 146 patients who the Trust have discovered did not have follow-up Out-Patient appointments booked as anticipated. If any of those patients have died prematurely as a consequence of any delay in their treatment, it seems to me that those deaths would need to be reported to this office
9	Dated 13 September 2016 Signature_____ Assistant Coroner for Plymouth Torbay and South Devon

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