Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Department of Health and Social Care** **39 Victoria Street** **London SW1H 0EU**
1	**CORONER** I am Mrs D HOCKING, Her Majesty's Assistant Coroner for the coroner area of Leicester City and South Leicestershire
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 01 March 2019 I commenced an investigation into the death of Fadzai CHITAKUNYE aged 45. The investigation concluded at the end of the inquest on 29 March 2022. The conclusion of the inquest was Natural Causes due to 1a) Haemorrhage into high grade astroglial brain tumour 2) Progression of hepatitis B infection following chemotherapy
4	**CIRCUMSTANCES OF THE DEATH** Fadzai Chitakunye was diagnosed with a brain tumour in 2010. Her compliance with the advised treatment was not always consistent. She had been diagnosed with hepatitis B in 2004 in Nottingham but this information had not been passed onto her general practitioner until 2010. She was not referred to a hepatologist and the oncologist treating her was unaware of her hepatitis B infection. If she had been, it is likely that Mrs Chitakunye would have been given anti-virals whilst having the chemotherapy treatment which might have improved her liver disease. Mrs Chitakunye died from a haemorrhage into her brain tumour on the 26 February 2019 at Leicester Royal Infirmary. It is not entirely certain whether the haemorrhage was exacerbated by deranged coagulopathy due to her liver disease.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: In this case the transfer of the notes from the deceased's Nottingham general practitioner to the Leicestershire general practitioner took 11 months as reported to me by the GP. She

	also reports that notes still take about 16 weeks to be transferred between GP's. Important information about the patient's medical history may be missed particularly if the patient is not able to communicate effectively with the new GP.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 May 26, 2022. 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 Nelsons Solicitors Leicester – representatives for the family Browne Jacobson's Solicitors – representatives of University Hospitals of Leicester NHS Trust CMS Law – representatives of the general practitioner I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 31/03/2022**  **Mrs D HOCKING** **Her Majesty's Assistant Coroner for** **Leicester City and South Leicestershire**