ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England – Primary Care Complaints Team**
1	**CORONER** I am Abigail Combes, assistant coroner, for the coroner area of South Yorkshire (West District) hearing this case on behalf of West Yorkshire Eastern.
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 13 November 2020 an investigation commenced into the death of David John Nash born on 26 August 1994. The investigation concluded at the end of the inquest on 20 January 20223. The conclusion of the inquest was:- David died on 4 November 2020 at Leeds General Infirmary as a result of a brain-stem infarction, arising from a cerebella abscess caused by mastoiditis. On 2 November 2020 there was a missed opportunity to direct David to seek face-to-face care during his GP appointment that morning. Had he been directed to seek face-to-face or urgent care by the GP Practice it is more likely than not that he would have undergone neurosurgery approximately 10 hours earlier than he actually did; which at that time it is more likely than not would have been successful. The medical cause of death was: 1a: Brain-stem infarction 1b: Cerebellar abscess 1c: Mastoiditis
4	**CIRCUMSTANCES OF THE DEATH** 1. David first spoke to his GP on the phone about some swollen lumps on his neck on 14 October 2020. He was advised that he should have blood tests and these were booked for 2 November 2020. 2. On 23 October 2020 he further sought advice from the GP because he had pain in his ear and was complaining of an ear infection. At this telephone appointment there was an assessment for mastoiditis and otitis externa was diagnosed. Antibiotic ear drops were prescribed. 3. He was then spoken to on the phone again on 28 October 2020 because he felt that he had blood in his urine. He was advised to deliver a urine sample to the Practice which he did and when tested contained blood and white cells resulting in further antibiotics being prescribed. The view of the GP expert was that this was unlikely to be a UTI however there would be no basis on which a GP would link these symptoms to mastoiditis and therefore the treatment was not unreasonable on this occasion.

	4. From the evidence of [redacted], ENT consultant it is more likely than not that at some point in the days after this appointment, David began to develop the abscess that would ultimately prove fatal. 5. On 2 November 2020 David had a telephone consultation with an ANP at his practice. He had continued fever, pain behind his eye and sinus pain. He had had a negative covid-19 swab in the week prior to this appointment but nevertheless his blood tests were cancelled and he was advised not to visit the surgery but to take a further Covid-19 swab and await the results. This clearly unsettled David who was concerned to get his blood tests completed and the ANP gave reassurance that as soon as he had a negative covid-19 swab she would book him in for his blood tests and see him urgently in practice. 6. As the 2 November 2020 progressed David became increasingly unwell. This resulted in David's partner contacting NHS 111. She explained his symptoms and was advised that a clinician would call back within 6 hours. Unfortunately David then vomited and so his partner called NHS 111 again and was given the same advice. When a clinician did call David's partner was advised not to wake him if he was sleeping and to keep up to date with the codeine pain relief. About an hour later David began to be disorientated and his partner made a final call to NHS 111 resulting in an ambulance being called. 7. David was placed on the dental pathway for NHS 111 which meant that he missed the opportunity to be asked questions which may have identified mastoiditis. However this pathway at the time was not unreasonable for him on the basis of his symptoms. 8. David was taken to St James' Hospital initially. He was triaged quickly and a working diagnosis of either meningitis or encephalitis was made. Both of these conditions would be treated at St James'. He required a CT scan which was undertaken just over 2 hours after it was booked. This was within the context of an ED suffering significant pressures. 9. As soon as the CT scan was undertaken it was apparent how unwell David was and urgent steps were taken to transfer him to the LGI for neurosurgery. 10. Unfortunately whilst David was in the resuscitation part of ED he deteriorated very significantly and suffered a fall resulting in head lacerations. This fall did not contribute to his death but nevertheless represented an acute deterioration in his condition with his GCS going from 10 to 3 and requiring immediate ventilation. 11. David survived to the LGI and underwent surgery to insert an external ventricular drain. This appeared to be a successful procedure at first and David responded however he continued to deteriorate over the course of the 3 and 4th of November 2020 and clinicians determined that his condition was unsurvivable. 12. David died at the LGI on 4 November 2020.
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 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: – I heard evidence that David's father made a complaint to NHSE about the primary care service, namely the GP Practice, that David had had contact with. This resulted in a clinical review of that complaint by Dr D'Souza which was initially highly critical of the 4

	occasions of care which David had at his GP Practice (listed above) It appears that this complaint was handled without a clinical rationale from the GP Practice being provided which resulted in [redacted] reviewing his opinion once that information was provided in the anticipation of inquest proceedings. I heard evidence from the GP Practice that they were not made aware of the concerns raised by [redacted] until the inquest process had disclosed these concerns. I am unclear how the primary care complaints team ensure that the details from their clinical reviews are fully informed taking account of information provided from complainants and those involved in the clinical management of a patient and how that information is then shared back to the practice to ensure appropriate learning can be undertaken. I am also not clear of the process of cascading this information to the primary care network in general where that is appropriate to raise awareness of an issue or condition for example.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 Tuesday 28th March 2023. 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: Mr and Mrs Nash and Burley Park GP Practice. 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 other person who I believe may find it useful or of interest. In this case I have sent a copy of this report to NHS West Yorkshire ICB as the organisation which will take on responsibility for primary care complaints in 2023. 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.
9	**Signed:**  **Dated: Tuesday 31st January 2023**