Regulation 28: Prevention of Future Deaths Report

Christine Margaret Cumbers (date of death 22 April 2022)

	THIS REPORT IS BEING SENT TO: Clacton Community Practices Kennedy Way Medical Centre Kennedy Way Clacton – on – Sea CO15 4AB
1	**CORONER** I am Ms. Mellani: H M Assistant Coroner for Essex Coroner's Court, Seax House, Victoria Road South, Chelmsford, CM1 1QH
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29
3	**INVESTIGATION and INQUEST** On 10 May 2022 I commenced an investigation into the death of Christine Margaret Cumbers. The investigation concluded at the end of the inquest on 19 May 2023. The conclusion of the inquest was a narrative conclusion: **Christine Margaret Cumbers suffered with Hyperthyroidism and was admitted to hospital with a skin rash eruption secondary to Carbimazole use, a rare but recognised complication of this necessary Hyperthyroidism first line medical treatment. She developed sepsis during her hospital admission which was belatedly diagnosed and treated due to lack of continuity care caused by multiple ward moves. The belated diagnosis and treatment of sepsis more than minimally contributed to her death on 22 April 2022 at Colchester General Hospital, Essex.**

4	**CIRCUMSTANCES OF THE DEATH** Christine Margaret CUMBERS was born on 3 September 1948 and at the time of her death on 22 April 2022 she lived in Clacton-on-Sea, Essex.

	Mrs Cumbers was known to have Hyperthyroidism, Hypertension, Osteoarthritis, Hypercholesterolaemia and a stable Angina. On 29 March 2022, Mrs CUMBERS was admitted to Colchester Hospital, having presented with skin eruption following use of Carbimazole, prescribed for an overactive Thyroid, by her GP at above named Practice. Mrs Cumbers suffered an allergic reaction to the prescribed Carbimazole, she stopped Carbimazole and reported it to the GP practice on 21 March. She was seen by a GP on 22 March in person, on 24 March there was a failed home visit with no follow up call directly to Mrs Cumbers, on 25 March there was a consultation via telephone, on 28 March she spoke to reception and later a nurse over the telephone and on 29 March she was seen at home. The GP Practice carried out an internal review of the incident, including the consultations conducted by the various GPs and other clinical staff and produced a "Significant Event Analysis" report. This report was admitted as evidence as part of the coronial investigation and identified that a clinician should have followed up on the failed encounter and the consultation on 28 March did not meet the required standards and the management of the care was found to be wrong, leading to a delay in administration of antibiotics and hospital admission. The evidence showed that this event did not cause or contributed to the death on the balance of probabilities. However, the Practice confirmed in evidence that no actions have been taken to embed the learnings identified in the Significant Event Analysis report, to ensure the appropriate standards are upheld by the Practice's clinical staff when carrying out consultations and providing treatment.
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. The Practice, despite identifying shortcomings in their practice, took no action to implement the learnings identified in the Significant Event Analysis report and, as at the date of the inquest, no details of plans or timescales for implementation were available.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that your organisation has 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. 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 following. ● Mrs Cumbers' family ● The Care Quality Commission 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	**DATE 16.06.23** **SIGNED BY ASSISTANT CORONER – JEANE ROSA MELLANI**