

	<p>Kevin Smith was diagnosed through MRI as suffering from degeneration of his lumbar spine which caused impingement of his lower sciatic nerve resulting in chronic pain.</p> <p>Mr Smith experienced a development in his pain in early July 2023 with symptoms of back and chest pain, radiating into his neck. Mr Smith sought medical treatment from his GP in telephone calls with the surgery reception on 3rd, 4th and 5th July 2023.</p> <p>The response from the surgery was chaotic and at times the behaviour of those taking telephone calls was unprofessional and inappropriate.</p> <p>On 4th and 5th July 2023 Mr Smith was informed that he would receive a GP call-back, on both days that did not occur.</p> <p>On the evening of 5th July 2023 Mr Smith's family, frustrated with the lack of contact called 111 who diverted the call to the 999 service. An ambulance attended upon Mr Smith who, utilising an ECG diagnosed that Mr Smith was suffering a myocardial infarction. Moments later, Mr Smith lapsed into cardiac arrest, despite prompt and effective CPR his death was declare just after midnight on 6th July 2023.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ul style="list-style-type: none"> • The GP surgery cannot offer persuasive evidence that changes in procedures, staffing and training since Mr Smith's death have resulted in the improvement of, the recording of patient calls, the escalation of patient enquiries to GPs and the monitoring of GP call-backs to patients.
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th May 2024. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons to the family of Mr Smith. I have also sent it to the local Director of Public Health who may find it useful or of interest.</p> <p>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.</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p> <p>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.</p>

	You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.
9	[DATE] 11th March 2024 [SIGNED BY CORONER]

