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:** **1 [redacted], Ringmead Medical Practice**
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of Berkshire
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 11 April 2022 I commenced an investigation into the death of Paula Elizabeth ELSLEY aged 54. The investigation concluded at the end of the inquest on 06 February 2024. The conclusion of the inquest was that: On the 28th March 2022 Paula Elizabeth Elsley died at her home address in Birch Hill, Bracknell. She was suffering from undiagnosed lung cancer with a metastatic tumour in her brain. This secondary tumour itself lead to the formation of an abscess which caused her death.
4	**CIRCUMSTANCES OF THE DEATH** On the 9th December 2021 Paula spoke to a GP on the phone reporting an ongoing cough. She had previously reported a shortness of breath in November 2021 which improved with antibiotics. She had also reported left leg pain and her leg giving way in the same month. Paula was not assesed further on this occasion and given worsening advice. On the 5th January 2022 Paula spoke to a GP reporting a new chest pain. She was not assessed further and given worsening advice. On the 17th February 2022 she spoke to another GP reporting back and leg pains. She was offered an assessment at the musculoskeletal clinic but declined. Paula had visited an osteopath on the 8th February and did so again on the 21st February. On the 25th February 2022 she reported to a GP that she had almost collapsed and that her legs had felt like jelly. The GP was concerned by these symptoms and booked her for a face to face assessment on the 1st March 2022. On the 4th March 2022 Paula attended the emergency department with left leg weakness, new left arm weakness and intermittent headaches. She was admitted for further investigations but decided to leave prior to these being completed. An outpatient MRI was arranged. On the 16th March 2022 she returned to the emergency department due to the severity of her headaches which were causing her to black out. She was not admitted on this occasion and was due to attend her MRI on the 27th March 2022. She did not make this scan due to circumstances beyond her control. Paula was found unresponsive at home on the 28th March 2022 and declared deceased. A

	post-mortem examination revealed a primary lung tumour with abscess formation and a brain abscess. The brain abscess was likely the result of a secondary brain tumour.
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: (brief summary of matters of concern) **1. Smoking status** During the inquest I heard evidence that a patient's smoking status (current or former) was not routinely recorded by the GP practice in a manner that was immediately accessible when reviewing the medical records. I heard that it may be necessary to search through consultation notes and other records to discover this information and GPs do not necessarily have time to do so. A patient's current or former smoking status is relevant information for a GP considering whether a chest x-ray ought to be considered in line with NICE guideline entitled 'Suspected cancer: recognition and referral' (NG12). The GPs who gave evidence agreed that it would be helpful if this information was flagged and the GP practice has indicated that it intends to introduce such a system. However this is not yet in place and I am concerned that the risk of this information not being highlighted remains a current risk. **2. Thresholds for referral for a chest xray** Based on evidence heard at inquest I am concerned that at the time of Paula's death (March 2022) the same NICE guideline was not being routinely considered by GPs. I was very pleased to hear that the practice subsequently introduced their own internal tool for considering if the threshold for a chest x-ray had been reached and that this has been discussed at GP and partner meetings. However some 22 months have now elapsed since Paula's death and no formal policy has been prepared. I remain concerned that the risk of the guideline not being considered remains whilst the change is procedure is informal, especially when it needs to be disseminated to new or locum GPs and other healthcare professionals such as nurses, paramedics and physician associates.
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 April 02, 2024. 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 [redacted]

	[redacted] [redacted] [redacted] **Frimley Health NHS Foundation Trust** 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: 06/02/2024** **Robert SIMPSON** **Assistant Coroner for** **Berkshire**