REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1)The Secretary of State for Health and Social Care 2) Derby and Derbyshire Integrated Care Board
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 8th April 2024 I commenced an investigation into the death of Stephen Charles STRINGER .The investigation concluded on the 25thSeptember 2024 and the conclusion was one of Narrative: **Died from squamous cell carcinoma of the glottis where the significance of his symptoms including a prolonged period of hoarse voice was not appreciated until the cancer had progressed to Stage 4.The medical cause of death was 1a Squamous cell carcinoma of the glottis; II Asbestos-related interstitial lung disease, Ischaemic heart disease**
4	CIRCUMSTANCES OF THE DEATH Stephen Charles Stringer developed a hoarse voice from January 2023. The prolonged nature of his hoarse voice and its ongoing deterioration was not explored in detail or noted as a potential cancer red flag until 23rd October 2023. He was referred at that point on the 2 week wait to ENT. He was diagnosed by biopsy on 9th January 2024 with stage 4 squamous cell carcinoma of the glottis. He was treated palliatively. Earlier referral to ENT would probably have led to earlier detection of the cancer and increased the treatment options available.
5	<u>CORONER'S CONCERNS</u> 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. –

1. The inquest heard evidence that the GP practice had in accordance with the local requirements introduced an electronic patient enquiry service alongside a telephone service. Patients contacting the surgery had to select which stream within the practice their enquiry went to. It was not always clear from the headings whether the query would be seen by a GP or the admin team. Information that went into the admin work stream from a patient did not go onto the patient record and was not seen by a doctor.
   The GPs at the practice were unaware of this and patients had no way of knowing that the information they had sent in was not in the patient record. The practice involved in this inquest had taken steps since identifying the issue to mitigate the risks. However the evidence before the inquest was that the software in question was widely used by GP practices within Derbyshire and nationally.

2. The evidence from the ENT consultant was that it was important that where a patient presented with a hoarse voice that all health professionals explored for how long it had been an issue and whether there was a realistic treatable cause for it .In the absence of any clear cause such as a throat infection or where there was no clear response to treatment then a hoarse voice should be seen as a red flag symptom for laryngeal cancers and result in a referral on the 2 week wait. It was clear from the evidence at the inquest that unlike other cancer red flags such as blood in urine the significance of a persistent hoarse voice was not recognised by a number of different healthcare professionals who saw him.
   The inquest was told that early detection of laryngeal cancers through early referrals on the 2 week wait significantly improves the outcomes for patients because far more treatment options are open to clinicians.

3. A number of different health professionals had input into his care. This meant that there was no one health professional who had a good insight into his overall deterioration and symptoms. Where multiple practitioners were involved one person needed to maintain oversight or the electronic patient record needed to have easily accessible clear action plans and notes were required so that a patient and their symptoms could be seen holistically rather than a one off.

4. There was also evidence that there is limited public awareness of how significant a change in voice can be and recognising it as a potential cancer symptom. Greater public awareness of symptoms of laryngeal cancers would ensure the public were better placed to seek help at an early stage.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 10th December 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 namely [redacted] on behalf of the family, who may find it useful or of interest. 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	**Alison Mutch** **HM Senior Coroner**  **15/10/2024**