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:** **Attleborough Surgery** **Station Road** **Attleborough** **Norfolk** **NR17 2AS**
1	**CORONER** I am Samantha GOWARD, Area Coroner for the coroner area of Norfolk
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 04 July 2024 I commenced an investigation into the death of Derek William COLE aged 81. The investigation concluded at the end of the inquest on 25 March 2025. **The medical cause of death was:** 1a) Metastatic Prostate Cancer and Emphysema 1b) 1c) 2) **The conclusion of the inquest was:** Natural causes
4	**CIRCUMSTANCES OF THE DEATH** Derek Cole was diagnosed with prostate cancer after he had raised PSA (prostate specific antigen) marker levels which rapidly increased over a short period of time. An initial bone scan in December 2023 showed no evidence of metastatic spread, but a further scan on 7 May 2024 showed extensive metastatic disease. He was admitted to hospital on 27 May 2024 and was found to have raised inflammatory markers and an acute kidney injury secondary to infection. He was treated and improved sufficiently that he was fit for discharge, pending a package of care being sourced. While awaiting this he had a suspected chest infection which was also treated and from which he recovered. He was discharged to Dereham Hospital on 15 June 2024 for rehabilitation. In the early hours of 16 June 2024, he was found unresponsive in bed and in line with previously expressed wishes, no resuscitation measures were undertaken. The findings on the evidence heard included that a GP appropriately referred Mr Cole to the hospital Urology team in November 2023 due to high PSA of 25.6 (I was advised anything over 10 in a gentleman of Mr Cole's age is to be referred). He was seen by the Urology team in December 2023 and a bone scan showed no evidence of metastasis, which was reassuring, and they requested that the GP perform a further PSA test in 2 months, and this was done on 12 January 2024 and the result was slightly raised from the earlier test at

	37. There was then a further PSA test in February which showed what a Urologist who gave evidence described as a significant raise to 156.3. His evidence was that this was an unusually high rise in a short period of time for a man in his 80s. This was therefore something which should have been flagged up immediately to the Urology team by the GP receiving the result, but it was not as they believed (but were unable to explain why) he had a follow up appointment shortly with urology and that they would see the result then. There was then another test in April, with a PSA which was said to be very high at 510. At this time a check was made by a GP that there was a follow up appointment in place, and this led to a further bone scan which was done 7 May 2024 and confirmed multiple metastases. Had the results from February 2024 been flagged to Urology, on the balance of probabilities, Mr Cole would have undergone further tests at the hospital to check the PSA raise was genuine, which it would have been, and treatment would have started in February or early March. This would have been the same treatment as was later started in May. The evidence in this case was that the extent and speed of the spread was very rare in a man of Mr Cole's age, and this was due to it being an aggressive form of the cancer and that, on the balance of probabilities, earlier commencement of treatment would not have altered the outcome or changed the treatment options which were suitable.
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: 1. It was accepted that the GP practice, when asked to perform tests by secondary services, should notify them of the results if they are abnormal. It was accepted that it should be confirmed in such circumstances that a follow up appointment is in place and considered whether any abnormal results should lead to a request for a more urgent review. It was also accepted that there was learning for the practice regarding this and that this could be discussed at a Significant Event meeting. However, despite Mr Cole dying in June 2024, at the time of inquest, 9 months later no such meeting or learning had taken place. While the evidence is that earlier specialist input would not have altered the outcome for Mr Cole, it is a concern that for other patients, a delay may impact upon their treatment options and prognosis. 2. The evidence was that any clinician could identify a concern for these meetings, or that usually it was for the Practice Manager to raise these when they were aware of a concern. The Practice were aware of the concerns as the inquest was listed and concerns raised by the family about delays were sent to the Practice to consider when providing their evidence for the inquest. However, this still did not trigger a review or any learning. It is therefore a concern that the Practice does not have a sufficient system in place to learn from such events which creates a risk that future deaths may occur in similar circumstances.
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 May 21, 2025. 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: NOK – spouse. I have also sent it to CQC HSSIB (Health Services Investigations Body) Healthwatch Norfolk who may find it useful or of interest. 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: 26/03/2025** S. Goward **Samantha GOWARD** **Area Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH