ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Helen Carr Chief Executive Sheridan Teal House Unit 2 Longbow Close Pennine Business Park Bradley Huddersfield HD2 1GQ
	CORONER I am David Hinchliff, Senior Coroner for the coroner area of West Yorkshire (Eastern Area)
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 30th October 2013 I commenced an investigation into the death of Anne Whitworth aged seventy-eight. The investigation concluded at the end of the inquest on 4th July 2014. The conclusion of the inquest was Anne Whitworth was a widowed lady aged seventy-eight years who had suffered with diarrhoea for two weeks. She saw her GP on 30th August 2013 regarding this, who arranged for her to see a gastroenterologist for further investigations. By 8th September 2013, Mrs Whitworth was now suffering with constipation. She saw a doctor at the Local Care Direct Drop-In Centre when it was thought that she was constipated and a laxative was prescribed. Mrs Whitworth became acutely unwell later that day and was taken to St. James's University Hospital, Leeds by ambulance where her death was confirmed at 2205 hours on 8th September 2013. A post mortem examination reveals the cause of her Intestinal Obstruction was a Volvulus of the Sigmoid Colon which was not identified at her previous GP and emergency appointment. I concluded that this to be a death from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mrs Whitworth had seen her own GP on 30th August 2013 complaining of a two week history of diarrhoea. Her GP was concerned about her symptoms and arranged a referral to a gastroenterologist for further investigation. This referral had not been achieved by the date of death. 2. Mrs Whitworth developed severe stomach pains and shortness of breath on or around 8th September 2013. She was taken by her son to a Local "Drop-In Doctor" and the attending doctor diagnosed a blockage in her bowel and prescribed medication and advised her to see her GP if her symptoms did not

	resolve. 3. Later that day her pain became considerably worse. An ambulance was called and Mrs Whitworth was taken to St. James's University Hospital, Leeds at 2130 hours on 8th September 2013. Mrs Whitworth suffered a respiratory and cardiac arrest on route to hospital. Despite all efforts, her death was confirmed at 2205 hours on 8th September 2013. 4. A post mortem examination showed the cause of death to be 1(a) Aspiration of Gastric Contents due to (b) Intestinal Obstruction due to (c) Volvulus of Sigmoid Colon.
	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. – 1. The Emergency Doctor stated that had he been aware of the GP consultation on 30th August 2013 and her then symptoms and the fact that a referral to a gastroenterologist had been made, his management of Mrs Whitworth would have been different. 2. He explained that out of hours he could not access Mrs Whitworth's medical records. Their computer systems were not compatible and therefore he could not access her medical records electronically which is a major handicap to GPs working on urgent presentations out of hours. 3. The Out of Hours GP conceded that there was a missed opportunity to escalate Mrs Whitworth's treatment options.
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. That the Local Care Direct organisation should urgently explore and investigate the possibility of implementing compatible computer systems with GP practices and Doctors operating out of hours consultations in "Drop-In Centres" so that GPs who see the patients of others often in an emergency when such patients are vulnerable and who might be poor historians and have limited communication skills may not adequately be able to explain their recent medical history.
7	**YOUR RESPONSE** As stated, had the Out of Hours GP been able to access Mrs Whitworth's medical records electronically, his management and approach could have been different in that had Mrs Whitworth been sent to hospital, an appropriate diagnosis of her symptoms and resultant surgery could have altered the outcome.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner. 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]** 30th July, 2014 **[SIGNED BY CORONER]**