Our ref: [redacted]

Wednesday 20 January 2021

Chief Executive
Warwick Hospital
Lakin Road
Warwick
CV34 5BW

Tel:
Fax:
Email:

Mr Sean McGovern
Senior Coroner for the Coventry and Warwickshire Area
The Coroner's Office
Warwickshire Justice Centre
Newbold Terrace
Leamington Spa
Warwickshire
CV32 4EL

PRIVATE AND CONFIDENTIAL

Dear Mr McGovern, Sean,

Regulation 28 report – Mrs Eleanor Sherman DoB 12/04/1948 DoD 25/11/2020

Thank you for your Regulation 28 report dated 26th November 2020 relating to the inquest of Mrs Eleanor Sherman. I was sorry to read of your outstanding concerns at the conclusion of the inquest and hope that the following information will provide you with further reassurance.

Following receipt of your report, the Trust convened a Working Group to review and critically reappraise the care and decision-making related to Mrs Sherman. That Group included our Medical Director, Director of Nursing, Head of Governance, a number of consultant physicians from both the Emergency Department (ED) and the Acute Medical Unit (AMU) and senior clinical nursing staff within ED. The Group explored, and reflected upon, a number of points relating to Mrs Sherman's care including the adequacy of the actions arising from the Trust's Root Cause Analysis (RCA) Investigation that were outlined at the Inquest.

An updated position on the actions listed in the Action Plan of the RCA Investigation can be found below but I can confirm that the actions outstanding at the time of the inquest have all now been completed.

In addition to these existing actions, the Working Group felt that there should be a Trust-wide, rather than just ED/ AMU, dissemination of the revised Acute Headache Pathway to ensure that the wider Trust clinical body was aware of it. To this end, the Pathway has also not only been disseminated via Acute Medical Admission's own intranet page, but also introduced via the Trust-wide Patient Safety Newsletter. It is now available for all staff to refer to on the Trust's intranet site.

Separately to reviewing organisational learning from this case the Trust's Medical Director has reviewed any previous clinical incidents that the consultant practitioner was involved in and has discussed his performance with his clinical director. The Medical Director has met with NHS Resolution, the General Medical Council's Employment Liaison Advisor and the practitioner, and has agreed with the clinical director a plan for the consultant practitioner's development in the light of this incident.

Chair: Chief Executive:

The Trust is committed to being environmentally friendly, therefore where possible we use 100% recycled paper. This paper has been made using no harmful chemicals in the manufacturing process.

Although our RCA Investigation of Mrs Sherman's care highlighted a number of care management concerns which have now been addressed, I am grateful that your Regulation 28 Report provided us with a further opportunity to consider and improve our care to patients with symptoms suggestive of subarachnoid haemorrhage.

The latest position on all of the actions arising from both our RCA Investigation and the further review arising from your Regulation 28 Report can be found at the foot of this letter.

I hope that this provides you with the assurance that you require but if, having read this letter, you have outstanding concerns, please do not hesitate to contact me.

Yours sincerely

[redacted]
Chief Executive

Action ref	Action	Action Lead(s)	Due date	Current status	Done date
10675	1. Grant Access to GPs in ED to e-records (Evolve) and Lorenzo - D/W IT, GPs to complete e-learning module on e-records (Evolve) and Lorenzo software	[redacted]	01/12/2020	Completed	11/01/2021
10676	2. Subarachnoid haemorrhage to be discussed as part of the Junior doctors teaching program with this case to be incorporated into Junior doctors teaching and handbook to share learning	[redacted]	31/01/2021	Completed	04/11/2020
10678	3. Doctors involved to reflect on the case and review NICE guidelines on headache. Junior staff to discuss it with their educational supervisor noting it on their Form R and appraisals.	[redacted]	31/01/2021	Completed	25/11/2020
10679	4. Learning from incident to be shared with staff working in AEC and ED via team meetings and newsletters	[redacted]	30/11/2020	Completed	11/11/2020
10680	5. Amendment of the ACP Triage Form to include GP concerns and re-design of the form used by MNPs in AEC to take down GP referrals Consideration to be given to whether this form part of the medical record and to ensure it is included where appropriate.	[redacted]	30/11/2020	Completed	13/10/2020
10682	6. Review processes within AEC to ensure referral letters are available and seen by Doctors prior to seeing the patient.	[redacted]	30/11/2020	Completed	15/10/2020
10681	7. Medical team to review processes to ensure improved access to AEC notes for ED staff, including considering real time scanning and making ED aware of AEC note location for re-presenters	[redacted]	31/01/2021	Completed	20/11/2020
10683	8. Awareness raising with ED staff to ensure they are aware that AEC discharge summaries are available immediately after the AEC visit on Lorenzo within the individual patient record (Letters tab on right hand side)	[redacted]	30/11/2020	Completed	20/11/2020
10684	9. Develop an Acute Headache pathway - ED and Acute Medicine to develop an SOP for the assessment and management of acute severe headache incorporating the Ottowa subarachnoid decision tool.	[redacted]	30/04/2021	Completed	03/12/2020