REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive Warwick Hospital** 2. **Mrs [redacted]** 3. **Chief Coroner**
1	**CORONER** I am S McGovern, Senior Coroner, for the Coroner area of Warwickshire
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 [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 1st September 2020 I commenced an investigation into the death of Eleanor Emily SHERMAN 72 years old The investigation concluded at the end of the inquest on 25 November 2020 The conclusion of the inquest was a Narrative Verdict Mrs Sherman was a woman of 72 years who died on 20 August 2020 at Warwick Hospital. Mrs Sherman's cause of death was determined by a post mortem examination to be 1a Subarachnoid and Intracerebellar Haemorrhage 1b Systemic Hypertension. **On 13 August 2020**, Mrs Sherman contacted her GP by telephone. He was concerned about her symptoms and referred her to the Ambulatory Emergency Centre(AEC) at Warwick Hospital. The GP telephoned the hospital and indicated that Mrs Sherman needed a scan to exclude a subarachnoid haemorrhage (SAH). He also emailed a referral letter explicitly stating that Mrs Sherman's presentation should be considered a SAH until proven otherwise. She was misdiagnosed and discharged without a scan. Neither the notes of the GP's telephone call nor the GP's email were seen by the treating staff except for final doctor who saw her immediately prior to discharge. **On 15 August 2020**, Mrs Sherman re-attended Warwick Hospital. She was seen by a doctor in Emergency Department. He did not have access to the GP's letter or notes from the attendance on 13th August 2020. The discharge summary from 13th August 2020 would have been available but medical staff were unaware of this. Mrs Sheman's symptoms were unchanged from her earlier attendance On 20th August 2020, Mrs Sherman suddenly collapsed at home and was brought to Warwick Hospital by ambulance. A CT scan performed at 15.41 hours confirmed a SAH. She died later that day. The clinical errors (two misdiagnoses and failure to read GP referral letter) and systemic errors (GP referral letter and AEC notes not available on 15th August 2020)

	contributed to her death and constitute neglect notwithstanding her presentation of SAH was atypical.
4	**CIRCUMSTANCES OF THE DEATH** See above
5	**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 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) Two misdiagnoses at Warwick Hospital notwithstanding the GP specifically stating in writing that Mrs Sherman should be treated as a SAH unless a CT scan showed to the contrary (2) Systemic errors regarding the inability of the GP team at Warwick Hospital to access the electronic record and the slowness of notes being scanned on to the system.
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 21 January 2021 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 Mrs [redacted] (daughter) 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 other 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
9	**26 November 2020** **S. McGovern**