Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>THIS REPORT IS BEING SENT TO:<br><br>1. Chief Executive, Specsavers uk |
| 1 | **CORONER**<br><br>I am **Caroline Saunders,** Senior Coroner for the Area of Gwent |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On **18/10/19** an investigation was opened into the death of **John BERROW**<br><br>The investigation concluded at the end of the inquest on: **1/12/20**<br><br>The conclusion of the inquest was recorded as: **Natural Causes**<br><br>The medical cause of death was:<br><br>**1a) Subarachnoid haemorrhage**<br><br>**1b Ruptured berry cerebral aneurysm** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On 11th October 2019 John Berrow attended the Specsavers Opticians in Newport because he was suffering from unequally sized pupils. John stated that his eyesight was altered and he complained of increased pressure or heaviness.<br><br>An examination was performed by [redacted], the optometrist who noted the disparity in size. Mr Campbell considered whether John's symptoms could be as a result of an aneurysm or increased intracranial pressure, but the tests he performed reassured him that John's neurological function was intact. |

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| | [redacted] diagnosed a condition known as Adie's pupil an unusual neurological disorder in which the ability of the pupil to constrict is impaired, usually in one eye. This is not an emergency and as a result John was referred on a routine basis to the eye hospital.<br><br>John left the opticians at about 13:00hrs<br><br>John then went to the Queen's Hotel in Newport and collapsed at about 15.25pm, he was resuscitated and taken to hospital. On arrival at hospital all attempts were made to fully resuscitate John but sadly his condition was irretrievable and John died at 16:50 hours.<br><br>The cause of John's death was confirmed as a ruptured Berry Aneurysm. The neurological symptoms including unequal pupil size that John exhibited at his assessment at Specsavers should have resulted in John being advised to attend hospital for assessment. Given the severity and nature of his collapse however, there is no evidence that John's death would have been avoided. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest, 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.<br><br>The **MATTERS OF CONCERN** are as follows: -<br><br>[redacted] gave oral evidence at the inquest hearing. In evidence he admitted that he failed to consider unequal pupils alone as a sign of increased intracranial pressure due to a bleed or aneurysm and has rectified this in his current practice.<br><br>He also stated that there were no practical reference tools or clinical manuals available to him within Specsavers and was dependent upon referring to Google to assist him in his clinical decision making.<br><br>I was also informed that whilst [redacted] shared his experience locally, that there is no mechanism for disseminating information relating to clinical incidents or to improve learning from similar events amongst practitioners at Specsavers. |
| 6 | **ACTION SHOULD BE TAKEN** |

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| | In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.<br><br><u>I should be grateful if the following information be provided to me:</u><br><br>Confirm the resources available for clinical staff working at Specsavers to access up to date clinical information relating to potentially life threatening conditions.<br>Confirm how information relating to Mr Berrow's death and his presentation is to be disseminated to minimize the risks of missing symptoms allied to Berry Aneurysms in the future. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely **4/3/2021** I, the Coroner, may extend this period<br><br>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 necessary |
| 8 | **COPIES AND PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and the following Interested Person (s)<br><br>. The family of John Berrow<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>The Chief coroner may publish either or both in a complete or redacted 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 7/1/2021**<br><br>Signed<br><br>Caroline Saunders<br><br>**Her Majesty's Senior Coroner for the Area of Gwent.** |