	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** EMIS, Ashfield Surgery Sutton Coldfield, CCG, NHS England
1	**CORONER** I am Emma Brown Area Coroner for **Birmingham and Solihull**
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 19 August 2020 I commenced an investigation into the death of Pardeep Singh PLAHE. The investigation concluded at the end of the inquest. The conclusion of the inquest was Misadventure 1a HYPOXIC BRAIN INJURY 1b SELF INFLICTED INJURY TO NECK 1c II
4	**CIRCUMSTANCES OF THE DEATH** The Deceased died at the Queen Elizabeth Hospital on the 12th August 2020 after he inflicted a catastrophic injury to his neck with a decorative samurai sword. He had become increasingly concerned over recent weeks about a physical health complaint which had been discussed with his GP on the 6th August and had caused him to attend the emergency departments of the Good Hope and Queen Elizabeth Hospitals on the 8th, 9th and 10th August 2020. This culminated in a Urology Review on the 10th August 2020 where he was advised that further investigations were required and would be arranged but there was no immediate cause for particular concern. Mr. Plahe had appeared to understand the situation and had not given health care professionals any reason to suspect he would harm himself. However, he had still appeared extremely anxious to his family. There was a missed opportunity to review Mr. Plahe at 17:30 on the 10th August when he had been booked to have a telephone review with a General Practitioner but due to a technical problem with the surgery's computer system, the practitioner was not aware of the appointment and therefore did not make contact. It is not known what difference this review would have made
5	**<u>CORONER'S CONCERNS</u>** 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. On the 10th August at 17:30, hours before he inflicted the fatal wound to his neck, Mr. Plahe had a telephone consultation scheduled with his GP at the Ashfield Surgery. The appointment had been booked by his sister that afternoon. Due to a technical issue with the EMIS system the consultation list of the GP due to speak to Mr. Plahe did not update so he did not realise the appointment had been added to his list and did not call Mr. Plahe. Practitioners at the surgery had realised that the system was intermittently not updating consultation lists on or around the 30th July 2020 and had raised the issue with EMIS on the 4th August 2020. To date a solution to correct this intermittent problem has not been identified. Evidence was given at inquest that it does not just affect the Ashfield Surgery but has occurred at other surgeries across the country.

	2. Particularly for telephone consultations (where there will not be a patient physically present in the surgery to query why they have not been seen), the fact that the consultation lists do not always update creates a risk to life as a consultation could be missed for a patient with a medical emergency. 3. It is not known whether all GP Surgeries using EMIS have raised an alert that this error can occur. 4. To mitigate the risk of missing appointments the Ashfield Surgery has identified that if practitioners log out of the EMIS system and then log back on the consultation list will update. Therefore, all practitioners are advised to log out and log back in before completing their consultation lists. However, on one occasion since Mr. Plahe's death a locum GP carrying out a list at the surgery did not know to do this and missed an appointment. 5. The methods to mitigate this risk are vulnerable to human error if the practitioner is unaware of the need to log out of EMIS and log back in or if they forget to do so.
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 1 March 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 Interested Persons. 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	4 January 2021 Signature  Emma Brown Area Coroner **Birmingham and Solihull**