Regulation 28: Prevention of Future Deaths Report

Mr Harbans SINGH (died 27 April 2021)

THIS REPORT IS BEING SENT TO:

1. Chief Executive at Warwick Hospital

1. CORONER

I am: Sean McGovern, Senior Coroner for Warwickshire, Warwick Justice Centre, Newbold Terrace, Royal Leamington Spa.

2. CORONER'S LEGAL POWERS

I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and

The Coroners (Investigations) Regulations 2013, regulations 28 and 29.

3. INVESTIGATION and INQUEST

On 25th August 2021, I commenced an investigation into the death of Mr Singh (aged 85 years). The investigation concluded at the end the inquest on 15th October 2021 at Warwick Coroners Court.

4. CIRCUMSTANCES OF THE DEATH

Mr Singh was an inpatient at Warwick Hospital from 2 November 2019 to 14 January 2020. Whilst in hospital he was newly diagnosed with hypothyroidism and prescribed Thyroxine. On discharge from hospital neither the new diagnosis nor the medication were included in his discharge summary. The back-up system regarding discharge also failed so his new diagnosis and medication were not documented.

Mr Singh subsequently attended the hospital and had thyroid blood tests on 13.08.20 and 9.04.21 both demonstrating significant hypothyroidism. On neither occasion were the results highlighted as significant and appropriate medication was not prescribed.

On 23rd April 2021, Mr Singh was admitted to Warwick Hospital with symptoms of hypothyroidism and diagnosed with severe hypothyroidism. He died the following day.

Mr Singh died of natural causes in the context of neglect as set out above.

5. CORONER'S CONCERNS

During the inquest, the evidence and information 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:

i. During the inquest it was accepted there was a system failure regarding the discharge process and I am concerned that such a situation will not re-occur.

ii. I am concerned that the thyroid blood tests in August 2020 and April 2121 (described as demonstrating significant hypothyroidism) were seemingly not flagged nor acted upon.

6. ACTION SHOULD BE TAKEN

In my opinion, action should be taken to prevent future deaths and I believe that 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 10th December 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 following:

1. HHJ Teague QC the Chief Coroner of England & Wales Chief Coroner's Office, 11th Floor Thomas More, Royal Courts of Justice, Strand, London, WC2A 2LL. chiefcoronersoffice@judiciary.gsi.gov.uk
2. Mr Singh's family – [redacted]

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.

Date: 15th October 2021