	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive George Eliot Hospital NHS Trust, College Street, Nuneaton, Warwickshire, CV10 7DJ
1	**CORONER** I am LINDA KAREN HADFIELD LEE, assistant 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.
3	**INVESTIGATION and INQUEST** On 10 May 2022, the senior coroner commenced an investigation into the death of Carol Ann Welch aged 47. The investigation concluded at the end of the inquest on 6 January 2023. The conclusion of the inquest was a narrative conclusion: The deceased died of natural causes as a result of an undiagnosed cerebral aneurysm with subsequent spontaneous subarachnoid haemorrhage.
4	**CIRCUMSTANCES OF THE DEATH** Carol became unwell on the 27 April 2022 due to a cerebral aneurysm, this initially presented with similar symptoms to the migraines she tended to suffer from. She attended the emergency department of the George Eliot Hospital NHS Trust (GEH) and was sent home with a diagnosis of migraine. By the 28 April 2022 Carol was experiencing a sentinel bleed, and this led to a change in symptoms. She returned to GEH. The changes in symptoms were such that further investigations should have been undertaken (either a CT scan or a lumbar puncture) and such an investigation may or may not have revealed the presence of an aneurysm and that Carol was at risk of a subarachnoid haemorrhage. However, due to an incorrect diagnosis of migraine, further investigations did not take place and Carol was sent home. A further safety check, as laid down by Royal College of Emergency Medicine guidelines, was not followed. The guidelines state that where there is an unexpected return to the emergency department with 72 hours, there should be a discussion with a consultant before discharge.

	Carol suffered a cardiac arrest on 30 April 2022 and was admitted to the University Hospital Coventry and Warwickshire where she died on 1 May 2022.
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) The subsequent investigation by GEH highlighted two areas which needed addressing: • The need to raise awareness of subarachnoid haemorrhage masquerading as a migraine and the need to investigate possible neurological findings. This had been done by means of discussions in meetings and a poster displayed in a staff area. • Doctors were not familiar with the Royal College Guidance that there is a need to discuss with a consultant, all patients who unexpectedly return within 72 hours of discharge from the emergency department This had been done by circulating an aide memoire to be given to those in training and existing members of the department. (2) It was stated that the middle grade doctor who discharged Carol at her second attendance on 28 April 2022 was trained at a reputable institute overseas where Royal College guidance was not applicable. He had undergone a significant period of training and familiarisation and assessment at GEH, but it was not clear as to the way in which his understanding and appreciation of the appropriate guidelines had been assessed. (3) The document (described as an aide memoire) which notified all doctors of the Royal College Guidance referred to other matters such as punctuality and staff sick leave. Matters critical to patient care were not clearly identified and given appropriate prominence. (4) It did not appear that all doctors would have been present at meetings where the learning points were discussed. (5) The evidence made it clear that the individuals concerned had subsequently undergone appropriate training and reflection to avoid any recurrence. However, it was less clear how either learning point identified would be embedded in the team as a whole and conveyed to new members joining the team, particularly those joining the team at a more senior level, who would not previously have operated within the guidelines. (6) Although staff members would have the opportunity of accessing the material, there did not appear to be any checks to ensure that staff members had considered and understood the material provided. (7) It is requested that consideration be given to ensuring that where learning points relating to patient safety are identified, they are not only circulated to existing and future members of the team but that all doctors confirm their understanding and compliance. (8) It is also requested that there is a review of training plans for more senior doctors who would not be familiar with Royal College and other guidelines, to ensure that guidance critical to patient safety is easily identified and that familiarity with any such guidance is assessed.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 7 March 2023. 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: The Welch family I have also sent it to the Royal College of Emergency Medicine who may find it useful or of interest. 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	**11 January 2023** **[SIGNED BY CORONER]**