REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Medical Officer, South Warwickshire University NHS Foundation Trust** **2. [redacted], Chief Executive of South Warwickshire University NHS Foundation Trust** **3. Secretary of State for Health, Department of Health** **4. NHS**
1	**CORONER** I am Deborah Rachel Lakin, assistant coroner, for the coroner area of Coventry and 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 6 July 2023 I commenced an investigation into the death of Andrew Douglas Guillaume, aged 51. The investigation concluded at the end of the inquest on 29 December 2023. The conclusion of the inquest was a narrative verdict.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mr Guillaume was admitted to Warwick Hospital on 5 June 2023, having presented himself to his GP with shortness of breath and a cough. 2. Following a review on 7 June 2023, it was agreed that the likely diagnosis was severe aortic stenosis requiring an urgent Consultant to Consultant referral to University Hospitals Coventry and Warwickshire (UHCW) cardiology team, to be followed by a multi-disciplinary meeting with UHCW. 3. No Consultant to Consultant referral was made as the Consultant was unable to get through to the switchboard at UHCW. 4. Mr Guillaume remained at Warwick Hospital. 5. Mr Guillaume's condition worsened and on 16 June 2023 a plan was made to update the cardiothoracic surgery team at UHCW to expedite the surgery required but the Consultant was unable to get through to the switchboard at UHCW. 6. Mr Guillaume was admitted to the Cardiothoracic Critical Care unit at UHCW on 19 June 2023, but sadly died on 20 June 2023 due to a further sudden deterioration in his condition.
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 inability of Medical Consultants and staff to get through to the switchboard at UHCW on two occasions. (2) A previous incident in which a similar concern had been raised, had led to provision of an emergency GP phone number, that can be used by the clinical teams at SWFT, which is manned 24 hours a day and is prioritised over other calls. The Cardiology team had not been aware of this, nor did they have the telephone number. (3) Mr Guillaume was not discussed at the Multi-Disciplinary Team meeting with UHCW on 9 June 2023, as the referral had not been completed. (4) Had the referral been completed, the team at UHCW could have prioritised the patient's transfer.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 23 February 2024. 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: [redacted] – brother and sister-in-law of the deceased I have also sent it to Chief Executive, University Hospital Coventry and Warwickshire, 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	**29 December 2023** **Deborah R Lakin**