ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Holderness Health, Hedon Group Practice.** **2. Care Quality Commission.** **3. Royal College of General Practitioners.** **4. NHS England.**
1	**CORONER** I am Mr Edward Steele, assistant coroner, for the coroner area of East Riding of Yorkshire and City of Kingston Upon Hull.
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 18 June 2024, I commenced an investigation into the death of John Charles Spencer ("Mr Spencer"), aged 82 years. The investigation concluded at the end of the inquest on 12 May 2025. The conclusion of the inquest was Natural Causes. Box 3 of the Record of Inquest read: John Charles Spencer died on 21 May 2024. Mr Spencer had become unwell on 17 May 2024, insofar as having diarrhoea and vomiting, after eating fish and chips. On 20 May 2024, he had a telephone and a subsequent an in-person consultation with a GP out of hours surgery. Mr Spencer's past medical history included a right inguinal hernia repair in December 2010. That information was not available on the computer system being used by the GP out of hours surgery and it was not mentioned by Mr Spencer in consultation. The clinical diagnosis, consistent with his presentation, was gastroenteritis and safety net advice was given. Mr Spencer was discharged and found deceased at his home address, [redacted], the next day. There were no suspicious circumstances and there was no third party involvement. His medical cause of death was recorded as: **1a** Diffuse purulent peritonitis. **1b** Small intestine perforation. **1c** Recurrent inguinal hernia with obstruction.
4	**CIRCUMSTANCES OF THE DEATH** Mr Spencer became unwell four days before his death, on 17 May 2024. He was suffering symptoms that were later diagnosed, after a telephone and an in-person consultation on 20 May 2024, as gastroenteritis. When Mr Spencer was assessed by the GP out of hours surgery, including an examination of his abdomen, he had made no complaint in relation to hernia issues. The examination of his abdomen was considered

	to be consistent with the diagnosis given. In 2010, some 13 and a half years earlier, Mr Spencer had suffered from a right inguinal hernia. This was recorded in his GP medical history. The GP medical history was not available to the GP out of hours surgery. The post-mortem examination report stated that, in the opinion of the Consultant Histopathologist, Mr Spencer died due to a purulent peritonitis (inflammation of the abdominal cavity) secondary to a bowel perforation (rupture). That was caused by a section of the small bowel getting stuck and becoming obstructed within a right inguinal hernia, increasing the pressure within the bowel. Mr Spencer sadly died the day after the consultation, on 21 May 2024.
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 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) The GP medical history summary, populated by the GP that a patient is registered to, is not always accessible to a GP out of hours surgery. Evidence was given that there are various reasons for this, including the patient not providing consent for the exchange of this information. However, on some occasions, even when a patient has consented, the patient record systems utilised by the GP registered practice and the GP out of hours surgery, insofar as being different computer systems or for whatever other technological reason, prevented the exchange of information into the GP out of hours surgery. In this case, evidence was heard that the GP practice was using the EMIS system and that the urgent treatment centre (GP out of hours surgery) was using SystmOne. That fact caused the GP out of hours surgery to not be able to access Mr Spencer's GP medical summary. This situation generates a concern that, providing the patient has consented, key medical information may not be conveyed to the GP out of hours surgery which should be accessible to allow the appropriate exchange of medical information to inform what examinations should take place in an out of hours setting. This concern is particularly significant in circumstances where the patient does not say and/or present with the points in the medical history relevant to the GPs determination about what further examinations should occur flowing from the medical history of the patient.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 14 July 2025. 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 family of John Charles Spencer, City Health Care Partnership, [redacted].

	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. She may send a copy of this report to any person who she 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]** **19 May 2025**	**[SIGNED BY CORONER]** **HM Assistant Coroner Edward Steele**