Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 PHL Group (Partnering Health Limited)**
1	**CORONER** I am Rosamund RHODES-KEMP, HM Area Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 03 November 2023 I commenced an investigation into the death of Shre Kumar CHATTERJEE aged 44. The investigation concluded at the end of the inquest on 29 September 2025. The conclusion of the inquest was that: On 03 November 2023 I commenced an investigation into the death of Shre Kumar CHATTERJEE aged 44. The investigation concluded at the end of the inquest on 29 September 2025. The conclusion of the inquest was that: In mid- August 2023 Shre Chatterjee, aged 44, suffered a subdural haemorrhage, a rare type of brain bleed for someone of his age. He and his wife attempted unsuccessfully to get treatment for this on many occasions over the next 8 weeks. He sadly died at University Hospital on 12th October 2023. When by 25th September Shre Chatterjee described worsening Red Flag symptoms such as visual disturbance there was a missed opportunity to refer him to A &E for a CT scan. Again, on the 1st of October when, in addition to his other symptoms, he reported memory loss there was a further missed opportunity to refer him to A &E for a CT Scan. There was a final window closed to him in the early hours of 10th October when the ambulance crew did not convey him to hospital. Had he been taken to hospital on 25th September or 1st October a CT scan would have been arranged, surgery performed and on balance it is likely he would have survived. The short time frame on 10th October may make this less likely
4	**CIRCUMSTANCES OF THE DEATH** On about 14th August 2023 Shre Chatterjee aged 44 developed a sudden and severe headache. He sought diagnosis and treatment on multiple occasions. 16.08 23-UCC seen by a Dr- Examination-H/ache 2 days aching over the neck -probable frontal sinusitis 18.08.23-UCC seen by Advance Care Practitioner-Examination-sinusitis but prescribed different medication

	23.08.23- UCC seen by a 2nd Dr- Examination-Tension Headache as pain on palpation of neck-diazepam 3 days to relax neck and Amitriptyline 04.09.23- Shre sent an E mail to his named GP at Forestside-appointment booked 6th October 21.09.23- Waterside Physiotherapy & Osteopathy Clinic-1st attendance- soft tissue massage /spinal mobilisation-better movement /pain remained 25.09.23-111 Call- blurred vision 2 weeks-contact local services 2 hours (told him needed to see GP) 25.09.23- PHL OOH GP -Telephone Call -severe pain post osteopath but later pain the same, not able to take son to work because could not drive-no blurred vision mentioned in GP record- advice contact GP 24 hours (local service) urged him to see GP asap 28.09.23- 2nd attendance Waterside Physiotherapy & Osteopathy Clinic-Acupuncture 01.10.23- 111 call - Healthcare Worker recorded headache, memory loss, blurry vision and sleeping much more than usual - referred him for a clinical call back in 1 hour 01.10.23- 111/OOH Dr- headache ,memory loss, blurry vision, cannot work-?referred neck pain /tension headache - needs a scan to reassure – Revalidation- contact local service 24 hrs 05.10.23- Diabetic Retinopathy Review UHS- NAD 06.10.23- GP appointment cancelled due to GP sickness rescheduled for 10th October 10.10.23- breathless- wife called ambulance-111/SCAS 02:54-Chasing ambulance 10.10.23- SCAS 1st attendance 04:04-reassured by 10am appointment with GP ? MSK pain/Migraine? Worsening advice 10.10.23- Telephone Appointment 10am -Dr Ellen Neale spoke to wife as patient was asleep -referral to Neurology, letter same day 10.10.23-SCAS 2nd attendance 15:44-GCS3 + Pt had vomited -transferred to hospital 10.10.23- UHS ED after patient found unresponsive at home. CT imaging revealed an Acute on Chronic Subdural Haematoma 12.10.23- Shre Chatterjee sadly died at University Hospital Southampton due to an Acute on Chronic Subdural Haematoma.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) During the Course of the Inquest it became clear that whilst OOH/111 Doctors should be able to access direct booking with a patient's own GP in cases requiring a face to face assessment ,this facility is being blocked by some GP surgeries. This means that if a patient requires an urgent assessment the OOH Doctor can only refer them to contact the GP surgery. or direct to an Urgent Care Centre which is supposed to treat minor injuries and where they may still not be examined by a Dr, and blood tests imaging are not available. In the deceased's case despite numerous attempts to access a GP appointment he did not actually see a Doctor from 23rd August 2023 until he was eventually admitted to hospital with a by then fatal brain bleed on 10th October 2023. It was agreed by witnesses that if a Dr had seen the deceased face to face sooner , particularly one who knew him, then the seriousness of his condition would have been diagnosed more swiftly and he was likely to have survived.
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 February 11, 2026. 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 **111 Out of Hours** I have also sent it to who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 18/12/2025** [redacted] **Rosamund RHODES-KEMP** **HM Area Coroner for** **Hampshire, Portsmouth and Southampton**