REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

This report is made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Recipients
This report is being sent to:

- [redacted], Oak side Surgery, Honicknowle Green Medical Centre, Guy Miles Way, Honicknowle, Plymouth PL5 3PY
- [redacted] (wife)
- [redacted] (daughter)
- [redacted] (daughter)
- [redacted] (daughter)

Coroner

I am ANDREW JAMES COX, Assistant Coroner for the area of Plymouth, Torbay and South Devon.

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.

Investigation and Inquest

On 30 September 2013 I commenced an investigation into the death of Leslie Edmund Harding (Lez), aged 57. The investigation concluded at the end of the inquest on 2 April 2014.

The cause of death was found, at post mortem, to be:

1a Pulmonary Artery Embolism
1b Deep Vein Thrombosis of Left Calf
2 Pulmonary Oedema

The conclusion of the inquest was that Lez died from Natural Causes

Circumstances of death

Lez had a complicated past medical history. He was diagnosed with Multiple Sclerosis in 2002. He had also suffered with recurrent, periodic Pulmonary Emboli from 1997.

Lez had been a patient at your practice for over 20 years. Between 2002 and 2007, however, following a change of address, he was registered with another GP Practice. At Inquest, I heard evidence that he suffered two P.E's in 2003 and a further P.E. in 2005. Lex re-registered with your Practice circa 2007. He did not appear to have undergone a new patient assessment. It was not possible at Inquest to establish whether this was due either to the Surgery failing to contact Lez or Lez declining to attend for such an assessment.

By September 2011, however, [redacted] had referred Lez to the Haematology Department at Derriford Hospital. A report from a Clinician dated 13 September 2011 was read out at Inquest. It was noted that Lez had not had a clot in the previous four years and that Clexane was a suitable form of treatment for him given his difficulties in stabilising on Warfarin.

At Inquest, [redacted] gave evidence that Lez was poorly compliant with the Clexane regime. It was noted that in November 2011 and January and March 2012 the Surgery did not prescribe Clexane to him. It was further noted that between May 2012 and July 2013, no prescriptions for Clexane were written by the Surgery although a month's supply was believed to have been provided by Derriford.

The family disputed the extent to which Lez was non-compliant with the treatment regime. [redacted] said that Lez had been advised by a doctor at Derriford that he no longer needed to take Clexane.

On 18 September 2013, [redacted] was requested to see Lez at home. This followed his earlier admission into the Acute GP Service in Derriford on the 16 September where, after assessment, he self-discharged.

[redacted] gave evidence at Inquest that he found Lez to be angry and in discomfort. Lez was fed up that nothing was being done and he was complaining of pain in his chest.

[redacted] told me that he wanted to re-admit Lez who was resistant to this suggestion. [redacted] also said that he wished to consider whether Lez would be suitable for treatment with a new form of anti-coagulation, namely, Riveroxyban. Before prescribing this, [redacted] said that he wished to discuss the option with [redacted] to whom a referral had been made in August. He also wanted to check Lez's kidney function.

[redacted] told me that he attempted to telephone [redacted] on his return to the Surgery but was unable to contact him. He intended to follow up this approach but did not do so. At Inquest, [redacted] said that it slipped his mind for which he apologised.

[redacted] took no steps to treat Lez after seeing him until his collapse and death on the 28 September 2013.

I heard no evidence at Inquest as to whether, if anti-coagulation treatment had been started after the appointment on the 18 September Lez's death 10 days later could have been avoided.

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. [redacted] took no action during the period from 18 – 28 September 2013. Patients with a suspected life-threatening condition (Pulmonary Embolus) must be promptly treated. The system for ensuring that the treatment is provided must be robust. That is particularly the case where it is already known that the patient suffers from an underlying condition that makes him prone to the particular life-threatening event.

2. Your practice will have a number of other patients in receipt of anti-coagulation treatment following recurrent Pulmonary Embolii. Given the omission that appears to have occurred here, you need to ensure that no other omissions have happened with any of the other patients

3. At Inquest, I gained the impression that Lez was felt to be non-compliant with his anti-coagulation regime. It was plain from the prescription history that there were repeated gaps in the provision of medication that Lez required. There seemed, however, in my view, to have been little effort given to addressing the reasons why, or indeed if, Lez actually was non-compliant with his medication. By way of illustration, I was not shown a letter from the Surgery to Lez bringing to his attention that he had failed to collect his monthly supply of Clexane and warning him of the risks of failing to maintain the treatment regime.

   I heard evidence at Inquest that Lez could be an awkward patient. In my view, of itself, that is insufficient reason not to make every reasonable effort to ensure that a patient complies with an identified need for lifelong anti-coagulation.

4. I was advised that this death had not yet been reviewed in a significant events meeting. In my view, that should have taken place forthwith after Lez's death. You may wish to convene a significant events

Action should be taken

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

Your response

You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 June 2014. 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.

Copies and publication

I have sent a copy of my report to the Chief Coroner and to the Interested Persons listed above.

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.

A J COX **Date 8 April 2014**
Assistant Coroner
Plymouth Torbay and South Devon Area