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. **NHS Wales** 2. **NHS England** 3. **Royal College of General Practitioners** 4. **Welsh Assembly Government**
1	**CORONER** I am Paul Jonathan Bennett, assistant coroner, for the coroner area of Swansea & Neath Port Talbot
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 14th April 2011 I commenced an investigation into the death of Alan Vaughan Jones aged 63. The investigation concluded at the end of the inquest on 16th January 2015. The conclusion of the inquest was Addison's Disease as a result of neglect
4	**CIRCUMSTANCES OF THE DEATH** The deceased had Addison's disease and required steroid replacement medication which had been prescribed by his GP. In early April 2011, he developed gastroenteritis. He suffered with diarrhoea and vomiting and was unable to take his oral medication. He became progressively weak and unable to get out of bed. He required intravenous steroid replacement. He had a telephone encounter with his GP who was unaware that he had been diagnosed with Addison's Disease. This was because the software program containing his data did not show it as a critical part of his medical history, when the consultation screen was opened. The system was the EMIS program. The GP would be required to scroll through the whole of the past consultations or open a particular tab in the program to have seen the entry. In the context of a telephone consultation of 4 minute duration this was not considered to be unacceptable medical care. Advice given by the GP was to maintain fluid balance and avoid dehydration. Had the GP known of the Addison's and the inability to take essential medication, his advice would have been different. The deceased's daughter met with a different GP that same day (7th April 2011) and did a review of the medical history. She was able to access the whole of the records, She identified his condition of Addison's disease, but did not make arrangements to visit the deceased at home that evening nor arrange for him to be admitted to hospital as an emergency. His condition deteriorated and he died at 08.50 hours on the 8th April 2011.

	The evidence of the expert endocrinologist established causation, viz: that had he been admitted to hospital and received intravenous steroids ay any time up until midnight on the 7th April he would not have died. A short form conclusion of neglect was returned.
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. – The evidence of both of the GPs involved in Mr Jones's care, as well as that of the GP expert, clearly highlighted issues with the use of the electronic data on the patient system. These were:- (1) An apparent lack of adequate training on the use of the software systems. This meant that important clinical information could not be made available easily. The expert GP gave evidence that this training deficit was not uncommon. He had the experience of using 4 different software programs in his career and had identical issues over lack of training. (2) An apparent failure in the software programs themselves to highlight important diagnosed conditions as an alert, when the patient record is opened and to prevent any further steps being taken to navigate the program (and make any entries) without consciously closing the "alert" first.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR 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 22nd April 2015. 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], The family of the late Alan Vaughan Jones. 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	**DATE 18.02.2015** **SIGNED** [redacted]