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.** [redacted] Senior Partner, Springfield Medical Practice, 384 Liverpool Road, Eccles, Salford. M30 8QD
1	**CORONER** I am Alan Peter Walsh HM Area Coroner , for the Coroner Area of Manchester West
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 21st October 2014 I commenced an Investigation into the death of Jorge Emanuel Mousinho Assabay E Castro, 50 years, born on 24th March 1964. The Investigation concluded at the end of the Inquest on 14th April 2015. The medical cause of death was: 1a) Sudden Unexpected Death in Epilepsy 1b) Post-Traumatic Epilepsy 1c) Old Traumatic Head Injuries 2) Alcoholic Ketoacidosis The conclusion of the Inquest was Jorge Emanuel Mousinho Assabay E Castro died as a consequence of Post Traumatic Epilepsy arising from injuries sustained in an accidental fall on a background of alcoholic ketoacidosis in circumstances where he had not received his prescribed anti-epileptic medication for a period of time prior to his death.
4	**CIRCUMSTANCES OF THE DEATH** 1. Jorge Emanuel Mousinho Assabay E Castro died at Flat 222, Willowfold, 228 Worsley Road, Winton, Eccles, Salford on the 16th October 2014. 2. On 20th June 2013 Jorge was found unconscious in a street near to his home address at 222 Willowfold, 228 Worsley Road, Winton, Eccles, Salford by a male on his way to work. An investigation by the Greater Manchester Police concluded that there was no evidence of any third party involvement as to how Mr Castro came to be lay in the street and

his injuries did not suggest that he had been involved in a road traffic collision nor that he had been the victim of blunt trauma from a weapon. The evidence at the Inquest accepted that it was likely that he had suffered his injuries as a consequence of an accidental fall. Jorge was taken to the Salford Royal Hospital, where he had surgery on the 20th June 2013, being a right fronto-temporal craniotomy to evacuate an extradural haematoma, and he was transferred to the Intensive Care Unit followed by the High Dependency Unit. He was known to have had three seizures following the injury and prior to the surgery.

3. Jorge was discharged from the Salford Royal Hospital on the 14th August 2013 and he was prescribed sodium valproate as an anti-epileptic medication and the prescription of sodium valproate was 300mg three times a day with vitamins. Seizures noted in the period after a traumatic brain injury constitute immediate seizures and need not have any predictive value for future seizure disorder so at the time of discharge the sodium valproate medication was prescribed as a prophylaxis. However Jorge suffered another seizure in February 2014, which led to the diagnosis of Post Traumatic Epilepsy, and at that time sodium valproate was prescribed as a regular medication and not as prophylaxis but there was no reason to increase the dose of sodium valproate.

4. Following his discharge from Salford Royal Hospital, on the 14th August 2013, Jorge was monitored by [redacted] who is a Consultant in Rehabilitation Medicine at the Hospital, and his prescriptions for sodium valproate were issued by his General Practitioner at Springfield Medical Centre, 384 Liverpool Road, Eccles, Manchester. The prescription for sodium valproate was issued on a four weekly basis for the collection of the prescribed medication from the pharmacy on a weekly basis in a Venelink container.

5. There were concerns with regard to Jorge's compliance with medication and, following a review by [redacted] on 8th April 2014, [redacted] a letter dated 9th April 2014 to [redacted], a General Practitioner at Springfield Medical Centre, confirming details of the review. The letter confirmed that sodium valproate 300mg tds should continue but the letter stated 'the issue appears to be mainly with his regular adherence with his anti-epileptics. At the moment I have advised him to continue with Sodium Valproate 300mg tds. If there is one more episode of seizure I think we need to increase it to 400mg tds. At the moment I have not considered any antidepressants for him as he is keeping himself busy in the community. I shall see him in this clinic in six months' time as routine.' [redacted] arranged the next review in his clinic for the 24th October 2014.

6. General Practitioners at the Springfield Medical Centre continued to issue prescriptions for sodium valproate and reviewed Jorge at consultations arranged by appointment. The General Practitioner notes showed that the last prescription for sodium valproate was dated 2nd June 2014 and the prescription would allow Jorge to collect the Venelink container weekly with the final collection of sodium valproate under that prescription for the week commencing 26th June 2014. No further

prescriptions were collected by Jorge so that the last Venelink container received by him was dated 26th June 2014 for a period of seven days, which expired on 3rd July 2014. Accordingly, Jorge did not receive sodium valproate for the period from 3rd July 2014 until the time of his death on the 16th October 2014.

7. Evidence was given at the Inquest that Jorge was seen on three occasions at the Springfield Medical Centre after the 3rd July 2014 namely, on the 25th July 2014, on the 11th August 2014 and on the 18th September 2014. Jorge was seen on each occasion by a General Practitioner but his medication was not mentioned and there was no discussion in relation to the fact that he had not collected his prescription for sodium valproate for use after 3rd July 2014 and there was no review of the reference in [redacted] letter to the issue that Jorge had with regard to his 'regular adherence with his anti-epileptics'

8. The consultations with General Practitioners after 3rd July 2014 are referred to in the General Practitioner's notes and the notes record as follows:

   i. 25th July 2014 – Health check followed by consultation with General Practitioner due to the fact that Jorge admitted feeling low at times but denied any suicidal intent or self-harm. Jorge was advised regarding appropriate services if necessary eg. Crisis Team or GP.

   ii. 11th August 2014 – Jorge's diastolic blood pressure readings were found to be slightly elevated and it was arranged for him to have ambulatory blood pressure monitoring and and ECG, the results of which were both normal.

   iii. 18th September 2014 – Jorge attended with ongoing symptoms of low mood and anxiety together with poor appetite and a variable sleep pattern. It was agreed that treatment with Citalopram should commence and Jorge was advised regarding his alcohol intake and he said that he would engage with the Community Alcohol Team.

   There was a plan for a further review by the General Practitioner on the 2nd October 2014 but Jorge did not attend the review.

9. On the 16th October 2014 Jorge was found in a collapsed and unresponsive condition, having died at his home address at Flat 222 Willowfold, 228 Worsley Road, Winton, Eccles, Salford.

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. During the Inquest evidence was heard that:

   i. Jorge had not received sodium valproate medication for administration after 3rd July 2014 and he had been diagnosed with post traumatic epilepsy in February 2014 requiring regular treatment with sodium valproate as an anti-epileptic medication.

   ii. Jorge had been seen by General Practitioners at the Springfield Medical Centre on three occasions after the 3rd July 2014 without any review of the fact that he had not collected prescriptions for sodium valproate and the fact that the General Practitioner had received a letter from [redacted] alerting the General Practitioner to an issue in relation to his regular adherence with his anti-epileptic medication.

   iii. Jorge was known to be a vulnerable person, who consumed excess amounts of alcohol on a regular basis and who was being treated with Citalopram for depression prior to his injuries on the 20th June 2013 and subsequently on the 18th September 2014 prior to his death.

   iv. The General Practitioner's surgery at Springfield Medical Centre does not appear to have any systems to identify and highlight a patient who has not collected prescriptions, particularly in relation to vulnerable patients who will be dependent on medication for the control of a diagnosed condition and, as in the case of Jorge, to reduce the risk of episodes of seizure.
   In particular the computerised records do not have a system of highlighting any outstanding prescriptions at subsequent consultations so that a General Practitioner was not alerted to the fact that Jorge had not collected his prescriptions and would not have had a supply of his anti-epileptic medication after the 3rd July 2014 at any of the appointments following the 3rd July 2014.

   v. The evidence raised concerns that there is a risk that future deaths will occur unless action is taken to review the above issues.

2. I request you to consider the above concerns, particularly with regard to the following:

   i. The procedures and systems to highlight and alert General Practitioners in relation to concerns or issues raised by a Hospital Consultant, namely in Jorge's case by [redacted] with regard to Jorge's regular adherence with his anti-epileptic medication.

   ii. A review of your systems and procedures to alert General Practitioners in relation to the issue of prescriptions and the

	failure of a patient to collect prescriptions for prescribed medications, particularly in relation to vulnerable patients who have not collected or received their prescriptions for a period of time. iii. Training of all staff, both professional and administrative, in relation to record keeping and checks in relation to outstanding prescriptions, particularly when a vulnerable patient has not collected a prescription and has not received necessary and prescribed medications for a period of time.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 24th June 2015. I, the Area 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 1. [redacted] Sister of Jorge Emanuel Mousinho Assabay E Castro 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	**Dated** **29.04.2015**	**Signed** [redacted] **Alan P Walsh**