INQUEST TOUCHING THE DEATH OF DOREEN WOOD

REGULATION 28: CORONER'S REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: [redacted] Practice Manager Newgate Medical Group The Health Centre Worksop Nottinghamshire S80 1HP
1	**CORONER** I am Mrs Heidi Connor, assistant coroner for the coroner area of Nottinghamshire.
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 2 February 2015, I commenced an investigation into the death of Doreen Wood, DoB 25th May 1927. The investigation concluded at the end of the inquest on 23rd April 2015. The conclusion of the inquest was natural causes. The medical cause of death was : 1a Intra-cerebral haemorrhage. 2 Atrial Fibrillation.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Wood had been taking Warfarin since 2013, following a diagnosis of atrial fibrillation. Her INR was being monitored by her GP practice at the time of her death. We heard that, in April 2014, her INR was noted to be 8.9 (the normal range being 2 - 3). Mrs Wood was given Vitamin K to reverse the effect of the Warfarin, and her INR levels were monitored weekly for a number of weeks thereafter. Mrs Wood was admitted to Bassetlaw District General Hospital on 6th August 2014 following a fall. Her INR was above the normal range. The view of the treating consultant was that this was probably caused by 3 days of diarrhoea which Mrs Wood had suffered before her admission. She was discharged to Jubilee Court Nursing Home on 11th August 2014. Mrs Wood's INR was again raised on 29 August 2014, to 9.8. After treatment with Vitamin K, her INR went down to 1.4 on 2 September. On the 8th September, her INR result was 9. Tests carried out on 9th and 10th September gave results of 5.6 and 2.6 respectively. The test carried out on 10th September was the final INR check before Mrs Wood's

death. The GP planned to repeat the test again on 1 October, ie 3 weeks later.

The GP who gave evidence [redacted] accepted that his colleague who saw Mrs Wood on 10th September 2014 [redacted] should not have waited 3 weeks before her next INR check. [redacted] told us that this should have been done around a week later, ie by 17th September.

It was accepted by [redacted] that various factors affect INR, including weight, diet, medication and whether a patient is suffering with diarrhoea. He was not able to tell the court from the records what information was known to the practice about Mrs Wood in this respect. We heard that, in fact, she did suffer diarrhoea and was losing weight in the weeks before her death. It is not clear whether the GP was aware of this when he decided to wait 3 weeks before checking Mrs Wood's INR again.

I could not say, on the balance of probabilities, whether earlier review would have resulted in a different outcome. I found that the bleed which caused her death was likely to have been spontaneous. I heard evidence from her treating consultant at Bassetlaw District General Hospital (whose statement was read in court) that this bleed is likely to have developed acutely and rapidly, leading to her death on 25th September 2014.

INR monitoring by Newgate Medical Group Surgery

I took evidence from the team leader of the healthcare assistants who were responsible for taking blood from Mrs Wood for INR testing. They are employed by Nottinghamshire Health care NHS Foundation Trust. He said that all other GP practices in the area follow a protocol which includes the completion of a questionnaire,dealing with matters relevant to dosing by the GP. These practices also take responsibility for informing patients of their dosage decisions.

I heard that Newgate Medical Group surgery adopts a different approach. They require a face to face discussion with the healthcare assistant when making dosage decisions, and do not routinely use questionnaires. It was clear that the GPs are relying to some extent on the healthcare assistants to bring to their attention any relevant factors, such as those referred to above, on the presumption that the healthcare assistants know the patients well.

We heard from the healthcare assistants' team leader about how the task of taking blood from patients in the community is allocated. He told the court that the healthcare assistants would simply be allocated the task of attending patients in the community to take blood, and would not routinely be aware of problems with diet, weight, etc. They are not medically trained and would not necessarily be aware of what factors / information would be relevant to tell the GP before dosing decisions are made.

The GP who gave evidence was not able to point to any benefit in adopting this system, describing it as 'simply historical'.

In addition to the concern I have about relevant information being given to GPs to inform their dosing decisions, it was clear that the system adopted by Newgate Medical Group surgery creates something of a drain on resources for the healthcare assistant team. They have to wait in the surgery to see GPs face to face before dosing instructions are given, and also have to take responsibility for communicating these to the patient or carer.

This surgery appears to have delegated more of its responsibility for INR monitoring to the healthcare assistant team than the other 11 practices in this area. I am concerned that relying on healthcare assistants to volunteer information relevant to dosing decisions is unsafe. I heard no evidence to justify the fact that Newgate

	Medical Group surgery adopts a 'historical approach' which is different from other practices in the area.
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) I invite Newgate Street surgery to review their system of INR monitoring, in discussion with Nottinghamshire Healthcare NHS Foundation Trust. (2) Specifically, I invite the surgery to consider the use of standard questionnaires, and not rely on healthcare assistants to volunteer – or indeed be aware of – relevant clinical information to pass on to the GP when dosing decisions are made. (3) There has been no internal investigation of these matters within the practice, other than a discussion between two of the GPs who treated Mrs Wood. We heard that there are at least six other GPs at the practice who deal with decisions like this on a regular basis. I invite the practice to carry out its own internal investigation,to ensure that the learning from these events includes all GPs at the practice.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your practice 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 25th June 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 : 1. Family of Doreen Wood 2. [redacted] Head of Quality, Risk and Patient Safety, Nottinghamshire Healthcare NHS Foundation Trust. I have also sent it to the following : 1. Phil Mettam, Chief Officer, Bassetlaw Clinical Commissioning Group, North Road, Retford, Nottinghamshire DN22 7XF 2. NHS England, Birch House, Ransom Wood Business Park, Southwell Road West, Mansfield, Nottinghamshire NG21 0HJ 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	**29th April 2015** [redacted]