ANNEX A

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:

Daniel Elkeles – Chief Executive
Epsom and St Helier University Hospitals NHS Trust
St Helier Hospital
Wrythe Lane
Carshalton
Surrey
SM5 1AA

Keith Ward – Chief Executive BMA
Basement Office
78 Golborne Road
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[redacted] – Clinical Chair Surrey Downs CCG
Surrey Downs CCG
Cedar Court
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Mike Parish – Chief Executive Care UK
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Practice Manager/ Senior Partner
Linden House Surgery
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30 Upper Fairfeld Road
Leatherhead
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KT22 7HH

1	**CORONER** I am Caroline Topping, HM Assistant Coroner for the coroner area of Surrey
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 2nd February 2015 an investigation was commenced into the death of Ernest Higgs, an inquest was then opened on the 24th June 2015 which concluded at the end of the inquest on 7th April 2016. The conclusion of the inquest was that Mr Higgs died as a result of 1a. Aspiration Pneumonia 1b. Dysphagia II. Parkinson's Disease and Dementia. He died at Epsom General Hospital on the 20th January 2015 as a result of aspiration pneumonia. The conclusion as to death was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Mr Higgs was a resident at Milner House a nursing home in Leatherhead. He had been resident there since September 2014 when he was discharged from Epsom General Hospital. He had had a prolonged stay in hospital having initially been admitted following a fall but went on to develop UTIs, mild-moderate, dysphagia, Parkinson's disease, recurrent aspirational pneumonias, acute renal impairment, advanced small vessel ischaemic disease and hospital acquired pneumonias. In the course of this hospital admission he was fitted with a PEG feeder. On discharge his swallow had improved and he was no longer fed through the PEG feeder though his nutrition was supplemented with fortesip administered via the PEG. On the 15th January 2015 Mr Higgs was seen by a GP at Milner House following a decline in his health. She diagnosed aspiration pneumonia and prescribed antibiotics. Her advice to the home was not recorded in the multi-disciplinary held by the home. There was confusion over whether the GP told the home to make Mr Higgs nil by mouth that day. That advice was said to have been given by phone to an administrator at the home. It was not possible to make a finding about whether that advice was given owing to the lack of accurate records at the home but also the fact that no confirmation of the advice was sent by fax or email. Blood tests were also requested by the GP over the phone. There was a delay at the home in obtaining the written request and sample bottles from the surgery. As these weren't obtained until after 3pm on a Friday the home delayed taking the bloods until the following Monday. No message was sent to the GP's surgery to inform her of that delay. The results of the blood tests were in part required to inform a decision as to whether Mr Higgs should be hospitalised. An issue arose as to whether it would have been possible for the home to access OOH pathology. There was conflicting evidence which it was not possible to resolve about what provision was available at Epsom Hospital to process community blood tests outside the normal opening hours of the pathology laboratory. If such a service existed the home was unaware of it and subsequent enquiries following an SI report had not clarified the issue. Mr Higgs was admitted to hospital on the 19th January 2015 when his condition deteriorated and died from aspiration pneumonia the following day.

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 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. – (1) It was clear from the evidence that confusion arose over what advice had been given by the GP on the 15th January 2015. No record was made in the multi-disciplinary notes by the GP of her attendance at Milner House. Care UK the parent company of Milner House offered to liaise with their local surgeries to ensure the records were made by visiting GPs. However it appears that the BMA advice to GPs "Quality First Managing Workload To Deliver Safer Patient Care" advises against GPs filling in multi-disciplinary notes. There was no clarity about whose responsibility it was to fill in the notes. (2) Advice given by the GP over the telephone to make Mr Higgs "nil by mouth" was not recorded and no confirmation of that advice in writing was sent by email. There did not appear to be a safe system in place to ensure telephone advice was accurately sent and received. (3) There was conflicting evidence from Care UK and Epsom hospital about OOH provision at the hospital pathology laboratory for community care providers resulting in a significant delay to a diagnostic blood test being undertaken.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 2016. 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] Milner House Nursing Home. 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	**27th April 2016** **Caroline Topping**