REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Marianne Griffiths, Chief Executive Western Sussex Hospitals NHS Trust** **2. SECAMB** **3. IC24**
1	**CORONER** I am Dr David Skipp, Assistant Coroner, for the Coroner's area of West Sussex.
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 September 2015 an investigation into the death of Valerie Margaret Ellis was commenced. The investigation concluded at the end of the inquest on 21st April 2016. The conclusion, in narrative form, stated: *Mrs Ellis died on 6th September 2015 at home as a consequence of taking a prescribed blood thinning agent, Apixaban. Counselling as to the side effects of the drug was not given by the hospital and this, with non-compliance call handling by 111 and inexplicable premature closure of the case within IC24 may have contributed to death.* The pathologist gave cause of death as: 1a Massive Gastrointestinal Bleed due to 1b Apixaban 2 Ischaemic Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** Mrs Ellis was an 83 year old woman who had been treated in hospital for a fractured hip and discharged on the 14th August 2015. On 24th August she was readmitted with a cardiac arrhythmia stabilised by a combination of drugs along with Apixaban, a blood thinning agent. She was discharged from hospital on 29th August to her home with medication and a post hospital District Nurse visit on the 2nd September did not identify any unexpected problems and no further nursing needs were identified. On 6th September Mrs Ellis developed a nose bleed and at 18:31 hours her husband phoned NHS 111 for advice. He was informed that he would receive a call from a clinician within 1 hour but, although apparently a call was made, [redacted] who has an acknowledged hearing disability, did not either hear or respond. At 21:07 a further call was made to NHS111 and as a result it was suggested at 21:21

	that Mrs Ellis be taken to hospital. Circumstances meant that it was not possible for [redacted] to undertake this action and he phoned 999 at approximately 21:34. The initial Category C rated call was change to Red 2 and an ambulance attended at 22:10 but the patient was deceased. During the inquest there appeared to be missed opportunities which may have had an impact on Mrs Ellis' end of life. 1. On discharge from hospital on 29th August, although [redacted] was given a list of drugs that his wife was to take, there was no information or counselling given as to the nature of Apixaban, a novel anticoagulant. Details of side effects and the identification of bleeding complications were not given. Mrs Ellis was exhibiting signs of confusion and [redacted] had loss of high frequency tones but his evidence was unequivocal as to lack of counselling. 2. The community nurse did not identify any nursing needs. 3. The first call to 111 was difficult as a result of communication problems between the caller and the health advisor. The algorithm used by the health advisor did not make clear the appropriate pathway for Mrs Ellis' symptoms and vital information about the medication she was taking was not elicited, particularly the blood thinning agent. 4. A referral was made to IC24 for a clinician to speak to [redacted] This was undertaken but in view of lack of response a note was made to phone in 5 minutes. The file, however, was lost from the system in IC24 and the return call was not made. No explanation could be given as to the fact that the case was closed prematurely without further contact with [redacted] 5. A second call to 111 was made as Mrs Ellis' condition deteriorated. All the information had to be repeated and again there were communication problems. In neither call to 111 was advice sought from available clinicians by the health advisors. 6. [redacted] was asked to take his wife to A & E after the second call. He agreed although with no means to get his wife out of the house due to her bleeding and poor mobility he eventually resorted to dialling 999. 7. [redacted] gave information to the 999 operator that his wife's problem was a severe nose bleed .The call was therefore rated as category C and only when [redacted] phoned again to say that his wife was not breathing was the category raised to the highest category.
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) On discharge from the hospital the use of Apixaban in an elderly confused patient being cared for by a carer with hearing loss should have merited careful counselling by the clinicians and the use of a warning card. Whilst the hospital is taking steps to assess this area, my understanding is that no policy has been adopted and I feel it should be made a matter of urgency. 2) KMSS 111 provides a valuable lifeline for many patients and although health advisors are trained to follow algorithms they only have 4 weeks training followed by 2 weeks of sitting in with an experienced advisor. I am concerned about the training schedule, particularly for those with little or no background medical knowledge. Whilst reliant on algorithms, advisors must be able to recognise potentially fatal illnesses and

	deteriorating conditions as thousands of patients rely on this service for medical help. Clinical advisors on duty were not consulted in this complex case. The senior manager for Quality and Clinical Governance at KMSS 111 expressed concern at the algorithm used in the case of Mrs Ellis .The clinical algorithm called NHS Pathways is owned by the Department of Health and was felt to be imprecise but despite representations to the Department of Health by KMSS 111 for changes and improvement there has been no positive communication since February. 3) A disposition from 111 was made to IC24 for a telephone consultation by an on call clinician. This was received and logged and a call was made within one hour. There was no response by the carer and a note was made to call back within 5 minutes. Apparently the case was closed before this could occur; no explanation could be given as to why this happened. Training for clinical staff in the use of the computer system used by IC24 is essential but did not appear well organised and should be rectified. 4) The results of investigations by both KMSS and IC24 should result in a joint RCA. This has not occurred as yet and no date has apparently been arranged.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 14th August 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] at Brachers representing the Community Nurse Paula Head, Chief Executive of Sussex Community NHS Foundation Trust [redacted] at Henderson Chambers representing Mr John Ellis [redacted], Western Sussex Hospitals NHS Trust [redacted] son of Mrs Ellis 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 : 16th June 2016** **SIGNED :** Jenny Fish. pp **Dr David Skipp**