	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.Richmond Medical Centre** **2. Clinical Commissioning Group**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
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 27 July 2016, I commenced an investigation into the death of Timothy Simon Jones. The investigation concluded at the end of an inquest on 24th November 2016. The conclusion of the inquest was due to natural causes.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was known to suffer from Downs Syndrome, Epilepsy and Dementia. He required PEG feeding. He had frequent admissions to hospital with chest problems in the year before his death. He was admitted to Solihull Hospital on 13 July 2016 with difficulty breathing. He was treated for aspiration pneumonia and a DNAR order was put in place. He was discharged on 15 July 2016 at 17.00. He was readmitted at 22.43 the same day with a decreased level of consciousness and breathlessness thought to be due to further aspiration or hospital acquired pneumonia. He deteriorated and died on 17 July 2016 at 05.55. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a. PNEUMONIA 2. DOWNS SYNDROME. PEG FEEDING, DEMENTIA AND EPILEPSY
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 have concerns about record keeping at the practice. The residential home records recorded that the GP had visited the patient on 25 May 2016, however the GP could not find a record of that visit in the electronic notes. It is vital the accurate records are kept of contact with patients and clinical decisions made. 2. I heard evidence at the inquest that the residential home had requested several home visits from the GP, on 5 July 2016, 12 July 2016 and 13 July 2016, but the GP disputed this. The mechanism of communication within the GP practice caused concern in that several aspects of care were classified as "admin tasks" when they required further clinical assessment. The process of requesting and documenting requests for home visits needs to be clearer. The role of

	"admin tasks" needs to be clarified so that these are only used for true administration tasks. 3. There was no clinical assessment of the deceased by a GP after the 25 May 2016 despite his deteriorating condition and complex needs. 4. The GP's policy for home visits (copy attached) did not contain any reference to those with complex chronic conditions who were residents in care or residential facilities. The policy actively seeks to avoid home visits which may have influenced decision making in this case. 5. The deceased was diagnosed with aspiration pneumonia when he was admitted to hospital. He was at high risk of aspiration pneumonia. I heard evidence that the best antibiotics for aspiration pneumonia are co-amoxiclav. The deceased was not prescribed these in the community he was given amoxicillin instead. Consideration needs to be given whether guidelines should be produced to clarify which antibiotics are required in specific situations.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 27 January 2017. 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: The family CQC NHS England 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	24 November 2016 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**