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.** Mr Andrew Foster, Chief Executive, The Wrightington, Wigan and Leigh NHS Foundation Trust, The Elms, Royal Albert Edward Infirmary, Wigan Lane, Wigan WN1 2NN **2.** The Senior Partner, The Grasmere Surgery, Leigh Health Centre, The Avenue, Leigh WN7 1HR
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 the 24th November 2016 I commenced an Investigation into the death of Terence Ryan, 59 years, born 29th September 1957. The Investigation concluded at the end of the Inquest on the 24th August 2017. The Medical Cause of Death was:- Ia Pulmonary Thromboembolism Ib Deep Vein Thrombosis Ic Left Lower Limb Trauma The Conclusion of the Investigation was that Terence Ryan died as a consequence of injuries sustained in a Road Traffic Collision where no anti-coagulation treatment was available to him following his self-discharge from Hospital.
4	**CIRCUMSTANCES OF THE DEATH** 1. Terence Ryan (hereinafter referred to as "the deceased") died at on the 14th November 2016. 2. In August 2014 the deceased had a right Deep Vein Thrombosis in his thigh and a Pulmonary Embolus. In April 2015 the deceased had a further investigation for Deep Vein Thrombosis and it was not clear if this related to his previous Deep Vein Thrombosis or if this was a new event but he was

commenced on Dalteparin injections as an anti-coagulant for three months.

3. Dalteparin was subsequently changed to Rivaroxaban but this caused him to collapse and the Rivaroxaban was stopped and the Dalteparin injections restarted.

4. On the 15th July 2016 the deceased attended the Deep Vein Thrombosis Clinic when a Consultant prescribed Edoxaban 60mgs per day for long term anticoagulation on weekly repeat prescriptions to be issued by the General Practitioner. However when the Clinic letter was received by the General Practitioner from the Consultant, the prescription of Edoxaban was not added to the deceased's repeat prescriptions.

   The deceased had further consultations with the General Practitioner on the 10th August 2016, 30th September 2016 and the 14th October 2016 and during that time he had complained about pain and swelling in the leg and a repeat prescription for his medication had been issued. However, the anticoagulation was not discussed at the appointments and the repeat prescriptions did not include Edoxaban. Accordingly, the deceased did not receive Edoxaban or any other anticoagulation medication from the 15th July 2016, when the Consultant issued a prescription, until the date of his admission to the Royal Albert Edward Infirmary, Wigan on the 3rd November 2016.

   The General Practitioner giving evidence at the Inquest confirmed that, when the Clinic letter relating to the prescription of Edoxaban had been received by the Surgery, the prescription had not been added to Mr Ryan's repeat prescriptions, as it should have been, and the anticoagulation had not been considered at subsequent appointments.

5. On the 3rd November 2016 the deceased was in collision with a motor vehicle whilst crossing Atherleigh Way, Leigh at the junction with Kirkhall Lane, Leigh. He sustained a tibia fracture to the left leg and he was taken to the Royal Albert Edward Infirmary, Wigan, where the fracture was treated conservatively with a plaster cast and splint and he was admitted to the Hospital for physiotherapy and non-weight bearing non-operative treatment.

6. In Hospital he was prescribed Dalteparin as prophylactic anticoagulation, which was to be continued for two weeks from the time of his admission.

7. On the 10th November 2016 the deceased discharged himself from the Hospital against medical advice and he left the Hospital without any anticoagulation medication. The Dalteparin prescribed in the Hospital was not given to him because he walked out of the Hospital without waiting for a discharge notice and medication. Furthermore the Edoxaban, prescribed by a Consultant on the 15th July 2016, had not been included on the repeat prescriptions by the General Practitioner.

8. On the 10th November 2016 at 12:30 hours a Doctor had a bleep from the

Ward where the deceased was receiving treatment and the Doctor was informed that the deceased wanted to discharge himself immediately. The Doctor met the deceased and tried to establish the reason for his self-discharge and the Doctor discussed the treatment and the mobilisation plan with the deceased. The Doctor explained the need for the deceased to stay in Hospital, particularly in view of the previous history of Deep Vein Thrombosis. The deceased agreed to stay in the Hospital but at 13:00 hours on the same day the Doctor received another call from the Ward stating that the deceased had decided to discharge himself from the Ward, against medical advice, and he had walked off the Ward and left the Hospital.

The Doctor was concerned that the deceased had left the Hospital and he asked a Nurse in charge of the Ward as to the Hospital protocol when a patient self-discharges against medical advice. The Doctor was told by the Nurse that there was no protocol and he did not need to take any further action.

9. Following the deceased's self-discharge from the Hospital on the 10th November, 2016 there is no record of any contact with the General Practitioner and no record of any further contact with the Hospital.

10. On the 14th November 2016 he was found in a collapsed and unresponsive condition at his home address at [redacted] Leigh when he was diagnosed as having died.

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. On the 15th July 2016 a Consultant prescribed Edoxaban 60mg per day for long term anticoagulation treatment to be collected by the deceased on a weekly basis by repeat prescription issued by the General Practitioner and the Consultant sent a letter to the General Practitioner to confirm that plan of treatment. The repeat prescription for Edoxaban was not put on the deceased's repeat prescriptions by the General Practitioner and the deceased did not receive Edoxaban for administration after the 22nd July 2016 and he would not have had a supply of Edoxaban following his self-discharge from the Hospital on the 10th November 2016.

   The General Practitioner gave evidence that the Surgery had undertaken a "Significant Event Analysis" as to how the Edoxaban prescription had been missed and the investigation resulted in the following recommendations within the Surgery to prevent a recurrence:-

a. GP to review "active problems" on the computer system when any patient comes in, in order to ensure patient is on the appropriate treatment.

b. In respect of discharge letters directing new medication – the letter will be sent on a task to a prescription clerk, who will add the new medication and issue a month's supply. If necessary (depending on the type of medication involved) the task will include sending a request to the patient to see the GP for review in a month's time.

However, the General Practitioner confirmed that the above recommendations had not been included in any formal documented protocol and I was not satisfied that there was to be a note on a patient's record to alert a Doctor to a new medication subject to repeat prescription, bearing in mind that the deceased had seen a General Practitioner on the 13th September 2016, the 30th September 2016 and the 14th October 2016 without the omission being checked.

ii. The evidence at the Inquest revealed that the Wrightington, Wigan and Leigh NHS Foundation Trust does not have a protocol with regard to patients who self-discharge from the Hospital, particularly where they may be receiving necessary medication in the form of anticoagulation treatment. At the Inquest the deceased was identified as a vulnerable patient and the absence of a protocol is even more important in relation to a vulnerable patient.

There is no protocol to contact the Police, General Practitioner, Family or Social Services to bring it to their attention that a patient has self-discharged so that they become aware and they can make contact with the patient following his discharge to ensure that he has appropriate support and necessary medication.

2. I request the Senior Partner of the Grasmere Surgery, Leigh Health Centre, The Avenue, Leigh, to conduct a review of the documented protocols and systems relating to the recording of repeat prescriptions, particularly where repeat prescriptions are requested by a Consultant or a Health Professional outside the Surgery. The review should consider the training of Health Professionals, including Doctors, and check systems to ensure that any request for repeat prescription is recorded and within the knowledge of a Doctor treating a patient. The review should also consider an alert, either in the Notes or on the computerised system, to any Doctor or Nurse Practitioner to check medications, particularly new repeat prescriptions at the next appointment.

3 I request the Chief Executive of the Wrightington, Wigan and Leigh NHS Foundation Trust conduct a review of policies, protocols and systems when a patient, particularly a vulnerable patient, self-discharges from the Hospital without necessary medications so that all Health Professionals, including Doctors, can be aware of the protocols if a patient self-discharges from the Hospital in circumstances similar to the deceased.

6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 Friday 3rd November 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 Interested Persons:- 1. 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** **8th September 2017**	**Signed** **Alan P Walsh, HM Area Coroner**