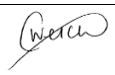
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Steve Gray, Chief Executive, Nuffield Health** **2. [redacted], Quality Care Partner, Nuffield Health**
1	**CORONER** I am Claire Welch, Area Coroner for the coroner area of Cheshire.
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 9 March 2018 I commenced an investigation into the death of Mary Jane Chapman, 55 years of age. The investigation concluded at the end of an inquest on 7 October 2019, after hearing evidence on 25-27 September 2019. The medical cause of death was 1a Large myocardial infarction 1b left descending coronary artery thrombosis 1c catastrophic antiphospholipid syndrome and my conclusion at the end of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Mary Chapman underwent an elective right total knee replacement at the Nuffield Hospital in Chester on 13 February 2018. She was discharged on 16 February 2018, at which point her platelet count was 74 meaning that she required a repeat blood test a week later to check her platelet count. Due to a combination of reasons relating to the management of the discharge process at the Nuffield Hospital, that blood test was not arranged: the discharging doctor did not arrange the follow up test to be done at the Nuffield Hospital; the discharging doctor verbally told the discharge nurse that the GP needed to do a follow up blood test in a week but did not document anything about this or give any instruction as to how this was to be communicated to the GP; the discharging doctor did not write directly to the GP to notify him of the need or reason for a follow up blood test in a week; the discharging doctor did not communicate the low platelet count to the consultant to enable him to write to the GP about the need for a follow up blood test in a week; the discharging nurse did not include the need for a follow up blood test in the discharge summary sent to the GP; and neither the discharging doctor nor the discharging nurse adequately explained the need for a follow up blood test to Ms Chapman. Ms Chapman was admitted to the Countess of Chester Hospital on 28 February because of a dangerously low platelet count of 7. Despite intensive medical treatment for a range of possible causes of it, she died on 4 March 2018. Her death was the result of a large myocardial infarction brought on by a left descending coronary artery thrombus, the underlying cause of which was the acute onset of Catastrophic Antiphospholipid Syndrome, a naturally-occurring auto-immune condition, the trigger for

	which could not be ascertained. Although I concluded that the failure to ensure that a follow-up blood test was arranged did not cause or contribute to the death, it is my opinion that ongoing uncertainties in the discharge process means there is a risk that future deaths will occur unless action is taken.
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) Although a Nuffield-wide 'discharge policy' has been created, the document is lengthy, unwieldy and generic. It does not clearly define who is responsible for doing what, or when, as part of the discharge process and there is no clear local or Nuffield-wide guidance document or policy that achieves this; 2) There is no clear local or Nuffield-wide guidance document or policy on how the need for critical post-discharge investigations should be arranged or communicated, or by whom or when; 3) In respect of (1) and (2) above there was no evidence at the inquest that clinical and nursing staff are now aware of their individual roles and responsibilities in the discharge process, other than as part of a new induction process, which self-evidently only captures new staff. Equally, despite 18 months having elapsed since the death, there was no evidence at the inquest to demonstrate that such changes as have been implemented have improved the quality, accuracy and robustness of discharge communications; 4) The inquest heard evidence that, since the death, the need for doctors to fully document their intended plan for follow-up investigations in the notes has been reinforced. Despite the importance of this as part of the discharge process, there was no evidence to demonstrate that this has resulted in improved record keeping or that the same has resulted in more robust and accurate discharge communications; 5) The inquest heard that it is accepted that there is a need for a multi-disciplinary team approach to risk assessing patterns with low platelet counts, but there was no document or policy addressing this new approach. There was no evidence of how such an approach should work in practice and there was no evidence to demonstrate that the new approach has improved the risk management of such patients; 6) The fact that Nuffield is a private hospital means that the doctors working there are likely to come from a variety of different hospitals and will be used to a variety of different working practices. Whilst the decision about what post-discharge investigations are required is clearly a matter of clinical judgment, the responsibility for ensuring that clear and unambiguous procedures exist to implement those clinical decisions lies with the Nuffield.
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 3 December 2019. I, the Area 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, the CQC, [redacted] (Ms Chapman's partner), the legal representative of [redacted] (Ms Chapman's siblings) and counsel for the legal representative of [redacted]. 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	 **8 October 2019**