**David Ridley**
**HM Senior Coroner**
**for Wiltshire and Swindon**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>THIS REPORT IS BEING SENT TO:<br><br>Care Quality Commission<br>City Gate<br>Gallowgate<br>Newcastle Upon Tyne<br>NE1 4PA<br><br>E-mail:- CQCInquestsandCoroners1@cqc.org.uk<br><br>Rt. Hon. M. Hancock MP<br>Secretary of State for the Health & Social Care<br>Department of Health & Social Care<br>39 Victoria St,<br>Westminster,<br>London<br>SW1H 0EU<br><br>E-mail:- coronersreports@dhsc.gov.uk |
| 1 | **CORONER**<br><br>I am David Ridley, Senior Coroner for Wiltshire and Swindon |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>I have enclosed with this Report a copy of my earlier Regulation 28 in report in this case relating to the death of Mrs. Vhari Ingall but which also included reference to another inquest that I have also recently concluded relating to the death of Mary Grace Johnson. This report is primarily produced as a result of evidence that I heard during the course Vhari's Inquest which I concluded on the 14 January 2020, returning a conclusion of suicide. Vhari's death having been found to be attributable to **1a) Drug overdose (oxycodone).** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>Please see earlier Regulation 28 Report attached dated 7 May 2020. |
| 5 | **CORONER'S CONCERNS**<br><br>**A) CARE QUALITY COMMISSION.**<br><br>During the Inquest into the death of Vhari I heard evidence from the Senior Partner of |

her GP surgery, New Court Surgery at Royal Wootton Bassett, Wiltshire as I had a concern in relation to the Treatment Escalation Plan/Do Not Resuscitation ("TEP/DNAR") form which [redacted] had completed with Vhari back in February 2017. I have enclosed a copy of that TEP/DNAR marked "A". As you will see the reason for issuing it was that Vhari had been diagnosed, late during the previous year, with a pancreatic tumour and she was considered for palliative care only. Towards the end of 2017, the Consultant at Great Western Hospital in charge of her care, [redacted] reviewed Vhari's case and the diagnosis changed to one of chronic pancreatitis as opposed to a terminal tumour. This was confirmed in writing to the surgery on the 17 September 2017. During the course of [redacted] evidence he explained to me the quite sensible reason why there is no fixed date review of these types of documents but did indicate that such a review was entirely appropriate when it was clinically appropriate to review the TEP/DNAR document. I was firmly of the view that a change in such a fundamental diagnosis should have ordinarily given risen to a review, however, I found no evidence that was recorded in Vhari's case to suggest that such a review was undertaken by the surgery even though there was a number of consultations with different doctors following Mr. Payne's letter of September 2017. The notes were completely silent as regards any such review being carried out. In fact I noted an entry in the records on the 5 March 2020 by one of the doctors at the surgery, [redacted] who referred to "reminder/alert: DNAR-priority: high." I also heard evidence from Vhari's sister, [redacted] that in going through Vhari personal possession she found no subsequent TEP/DNAR form after the February 2017 form.

I did consider sending a Regulation 28 Report to the surgery but heard evidence from [redacted] that they now have provided by the local CCG an add on to their SystemOne system called an Ardens module which assists in clinical decision making which they are also using in relation to recording TEP/DNARs. Whilst there is never a 100% guarantee that such a failure to review a document like this will not occur in the future and in respect of Vhari's case it was in no way contributory to her death, I was satisfied that this step was an improvement and an attempt to mitigate against the risk of such a recurrence.

Obviously, this package is available to surgeries within my own coronial area, but I am unclear as to the position in other areas and obviously you have a greater awareness of these sorts of matters as part of your inspection processes.

The Paramedics in both of these cases were faced with extremely difficult situations and on the front line are having to make very difficult decisions and need to rely on the best available information which needs to be accurate. In Vhari's case, Vhari herself was able to explain that the diagnosis of the pancreatic tumour was incorrect but that may not always be the case in every similar situation and in fact when the paramedics attended Mrs. Johnson she presented initially with a Glasgow coma scale of 7 and was not really responsive at any time when the paramedics were present.

I would be grateful if you would please consider as part of your inspection methodology including looking at the system in place for the management of TEP/DNARs, as my concern is that with inaccurate information and the inability to check that information that potentially decisions could be made that perhaps would not be made leading to allowing somebody to die that was based on inaccurate information.

**B) DEPARTMENT OF HEALTH**

Leading on from the above section addressed to the Care Quality Commission, whilst present practice places an obligation on the patient to have available the TEP/DNAR, even to the extent that I believe there is a practice of advising that a copy be left in the fridge/freezer at the patient's home. [redacted] himself did not have a copy of the TEP/DNAR which he signed on his case records at the surgery on the basis that he said that the original is left with the patient. I did express some surprise about that as to why at least a photograph of the document could not have been taken and transferred on to the case records, the original photograph then deleted from whatever device took it. As an alternative so that any health care professional can access the best available

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| | information as regards the existence of a TEP/DNAR, especially when the patient may not be able to assist at the scene and may not have told a relative of friend of its existence, I do question why there is not some central database or even as an alternative a regionalised database that could be accessed by the emergency services including health care practitioners. These are important documents and it may be the case that the individual concerned does not have a friend or relative that they can make aware of the existence of such a document and may be truly alone and unresponsive at the time the emergency services attend.<br><br>At the end of the day in respect of both of the above concerns I am genuinely concerned that health care professionals have the appropriate guidance on how to deal with these situations which has been remedied, at least, by the South Western Ambulance Service but also that they have access to the best available information as part of the decision making process in order to get the decision right, no only for their protection but also ensure that the genuine and true wishes of the patient are adhered to in accordance with their human rights. |
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| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, unless I have extended this period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Person,<br>Sister of Ms. Ingall<br>Medical Defence Union<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 19 January 2021<br><br>Signature_____<br>David Ridley, Senior Coroner for Wiltshire & Swindon |