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Date: 4 December 2020

Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted] Chief Executive NHS Digital, 1 Trevelyan Square, Boar Lane, Leeds, LS1 6AE

CORONER

1 I am Joanne Andrews Area Coroner for the Coroner Area of North East Kent

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)
2 Regulations 2013.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 29 October 2019 I commenced an investigation into the death of Ronald Richard TILLEY. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Narrative

3

1a Right Leg Ischaemia

1b Right Femoral Artery Thrombus

1c

II

CIRCUMSTANCES OF THE DEATH

Ronald Tilley presented to the Queen Elizabeth the Queen Mother Hospital on 16 October 2019 with an right ischaemic leg. He was previously on anticoagulation in the community but following concerns as to his capacity to manage his own medication this was ceased. An assessment as to his memory and capacity was requested by his GP of Kent and Medway NHS &
4 Social Care Partnership Trust which was completed but the GP did not receive the communications following the assessment. In the course of my investigation it was found that another GP surgery had amended the GP and correspondence address on the Personal Demographic Service and as such the correspondence did not go to the correct GP. The evidence in the case was that amendment to the Personal Demographics Service system is not notified to the existing GP as it would have done if there had been a change of care provider.

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.

5 The **MATTERS OF CONCERN** are as follows. –

(1) When the Personal Demographics service is updated or amended there is no notification sent to the existing GP noted on the system

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you NHS Digital have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 February 2021. I, the coroner, may extend the
7 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Northdown Surgery, Dr [redacted], Kent and Medway NHS & Social Care Partnership Trust and the family of Mr Tilley.

8 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 4 December 2020

Signature 

Joanne Andrews Area Coroner for North East Kent