ANNEX A

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. **Yorkshire Ambulance Service** 2. **NHS England/Improvement**
1	**CORONER** I am Abigail Combes, assistant coroner, for the coroner area of South Yorkshire (West District)
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 2 April 2015 I commenced an investigation into the death of Thomas Rawnsley born on 7 June 1994. The investigation concluded at the end of the inquest on 25 November 2020. The conclusion of the inquest was Natural Causes. Thomas died as a result of 1a: Global hypoxic-ischaemic encephalopathy 1b: Cardio-respiratory arrest 1c: Chest infection II: Down's Syndrome
4	**CIRCUMSTANCES OF THE DEATH** Thomas was a resident in a residential nursing home in Sheffield from July 2014. He had a chest infection in October 2014 and was prescribed antibiotics recovering. He then acquired a second chest infection in January 2015 and was seen by a GP on 29 January 2015. He was diagnosed with a chest infection and given antibiotics. The carers for him received verbal advice from the GP on administering the medication and how to monitor Thomas. He spoke to his mother on the phone on the night of the 29 January 2015 and that resulted in his mother raising concerns about his well-being and an ambulance being called out to see him. An ambulance attended on the evening of 29 January 2015 and a paramedic saw Thomas and was content that he did not need to attend hospital on that occasion and could be left at home. Thomas was left at home and appeared to be his normal self between 29 January 2015 and 1 February 2015.

On 1 February 2015 Thomas vomited and NHS 111 was contacted by the care staff at the home Thomas resided at for advice on whether to re administer his medication following him vomiting. The call was triaged by NHS 111 and passed to an out of hours GP to speak to staff. An out of hours GP spoke to staff approximately 1 hour after the phone call was made and did not take any history for Thomas and it appears that despite staff notifying the call handler that Thomas had a chest infection and was on antibiotics the GP did not access the record for Thomas and was not aware of this at the time that he gave clinical advice for Thomas. On this occasion the GP did not believe that this information was necessary in order for him to answer the question which he was being asked by care staff.

Thomas subsequently collapsed at the home in the early hours of 2 February 2015 (approximately 4 hours after staff spoke to Thomas' carers) and died in hospital on 4 February 2015.

There were concerns raised during the inquest about the quality of the 'safety netting' advice which was given to the care home staff looking after Thomas by the paramedic and whether this was sufficient information to support Thomas and identify a deterioration in his condition.

I heard evidence from from Yorkshire Ambulance Service who confirmed that since 2015 significant changes have taken place and that there is now an Electronic Patient Record ("EPR")which uses information inputted by the paramedic to provide standardised advice to leave for the patient following a consultation. This would then be inputted onto a patient information leaflet and left with a patient who is not conveyed to hospital. This allows more specific information to be left with the patient about their condition and signs to look out for and in the case of someone being looked after by carers this enables staff to share the same information and care for that patient consistently.

In the course of that evidence was asked how the information from the EPR which appears on the paramedic laptop, is placed on the patient information leaflet. He confirmed that at the moment there is a work around arrangement which means the paramedic would hand write on the patient information leaflet the information from the EPR and leave that with the patient confirmed that this could not be guaranteed to be 100% accurate on the basis of audits.

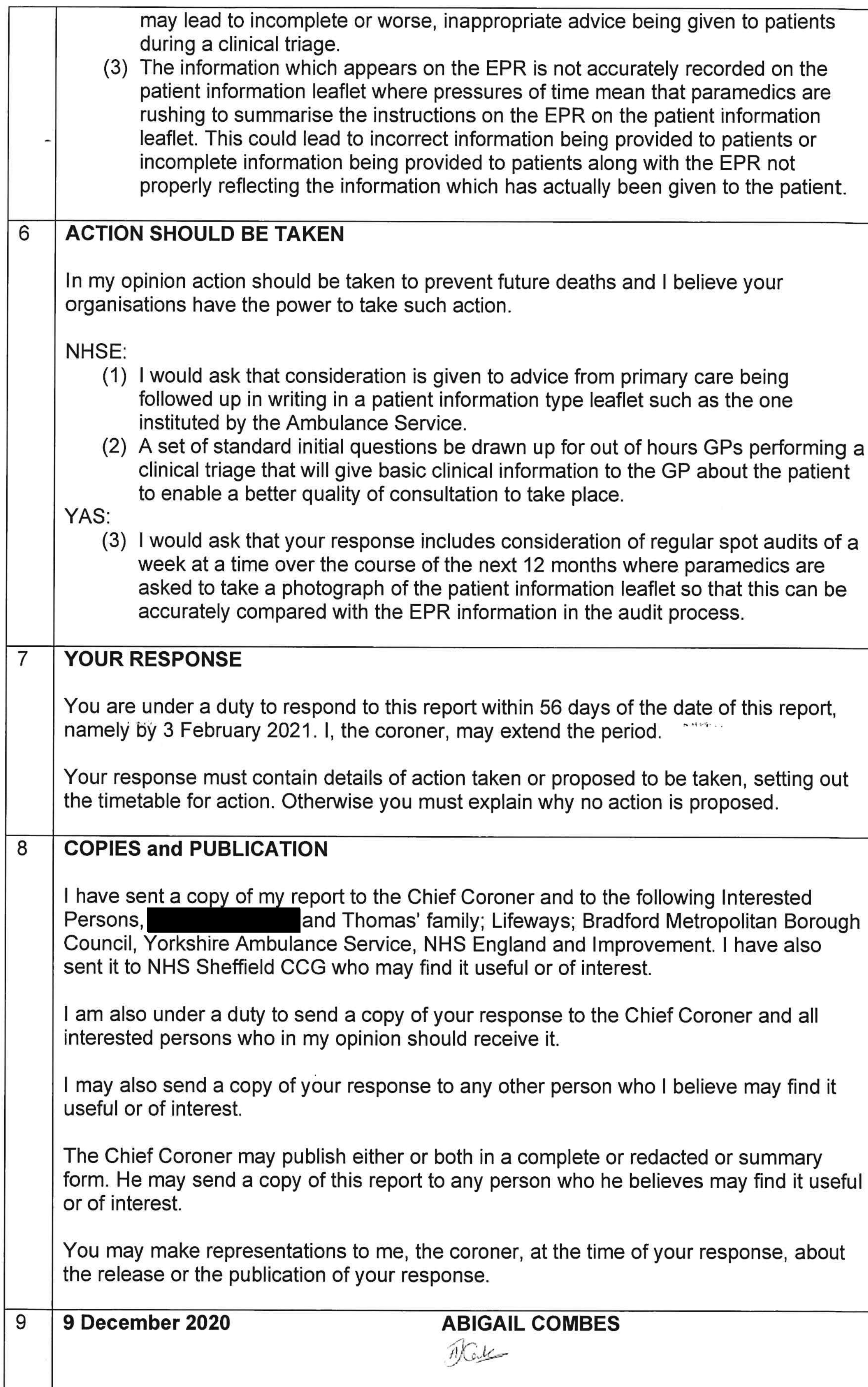
5 **CORONER'S CONCERNS**

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) Primary care are undertaking more and more virtual consultations with patients and the advice that is provided is inherently more risky over the phone with GPs not being in a strong position to assess the patients understanding of the advice that has been given in the same way as they can when the patient is sitting in front of them in the practice. This advice is not followed up in writing and therefore it may be misinterpreted or incorrectly passed from one care team to another in the event of someone, like Thomas, is having his care delivered by professional carers.

(2) There is a standard set of questions asked by the call handler on a 111 or 999 call which is not then replicated for clinicians who subsequently triage a patient. Without a standard set of initial questions asked it is entirely possible that clinicians will provide advice in isolation of other important matters. This could be as simple as current medications that the patient routinely takes or current diagnosis the patient has which impact upon the advice to be provided. This



-	may lead to incomplete or worse, inappropriate advice being given to patients during a clinical triage. (3) The information which appears on the EPR is not accurately recorded on the patient information leaflet where pressures of time mean that paramedics are rushing to summarise the instructions on the EPR on the patient information leaflet. This could lead to incorrect information being provided to patients or incomplete information being provided to patients along with the EPR not properly reflecting the information which has actually been given to the patient.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations have the power to take such action. NHSE: (1) I would ask that consideration is given to advice from primary care being followed up in writing in a patient information type leaflet such as the one instituted by the Ambulance Service. (2) A set of standard initial questions be drawn up for out of hours GPs performing a clinical triage that will give basic clinical information to the GP about the patient to enable a better quality of consultation to take place. YAS: (3) I would ask that your response includes consideration of regular spot audits of a week at a time over the course of the next 12 months where paramedics are asked to take a photograph of the patient information leaflet so that this can be accurately compared with the EPR information in the audit process.
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 February 2021. 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, [redacted] and Thomas' family; Lifeways; Bradford Metropolitan Borough Council, Yorkshire Ambulance Service, NHS England and Improvement. I have also sent it to NHS Sheffield CCG who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**9 December 2020** **ABIGAIL COMBES**