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 Chai Patel, Chief Executive of HC-One Limited, Southgate House Archer Street, Darlington, County Durham
1	**CORONER** I am Rachael Clare Griffin, Assistant 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 20th July 2015 I commenced an investigation into the death of Marie Quinn, otherwise known as Marie Pearson Quinn, born on the 25th October 1938. The investigation concluded at the end of the inquest on the 23rd October 2015. The Medical Cause of Death was: 1a Pulmonary Embolus 1b Deep Venous Thrombosis 1c Fractured Right Neck of Femur 2 Sub-optimal Deep Venous Thrombosis Prophylaxis The conclusion of the inquest was that Marie Quinn, also known as Marie Pearson Quinn, died as a consequence of injuries sustained in an accidental fall and a recognised complication of the subsequent surgical treatment of those injuries, in circumstances where the appropriate, and prescribed prophylaxis treatment was not given.
4	**CIRCUMSTANCES OF THE DEATH** On the 20th May 2015 Mrs Quinn fell in the kitchen at her home address at [redacted] sustaining a fracture to her right neck of femur. She was admitted to the Royal Bolton Hospital, Bolton and underwent surgery to repair the fracture on the 21st May 2015. She was discharged to Richmond House Nursing Home, Mitchell Street, Leigh for

rehabilitative care on the 29th May 2015 and was later discharged to her home address on the 22nd June 2015.

On the 13th July 2015 Mrs Quinn became unwell and was transferred to the Royal Bolton Hospital, where her condition deteriorated and she 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:

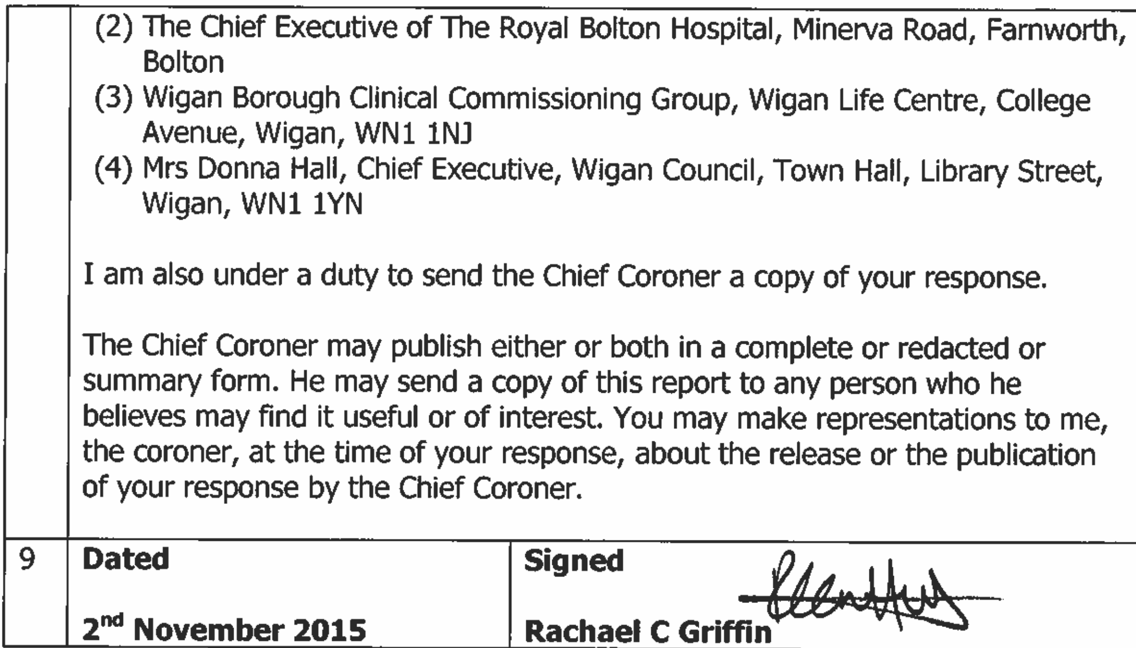
    i. The policy adopted by the Royal Bolton Hospital, Bolton for any person undergoing surgery to repair a fractured neck of femur is to administer prophylaxis treatment following that surgery to reduce the risk of developing a deep venous thrombosis. The treatment that should be given is prophylaxis medication, such as Dalteparin, a low molecular weight heparin, which should commence the day of the surgery and continue for a 4 week period following surgery, and mechanical prophylaxis whereby Flowtron boots are worn by the patient continuously for a specified period of time following surgery.

    ii. Following Mrs Quinn's surgery to repair her fractured neck of femur she was not given Dalteparin until the 22nd May 2015, the day after her surgery. She was then prescribed Dalteparin until the 18th June 2015, which would have been 4 weeks after the operation. Mrs Quinn was also not given Flowtron boots to wear after her surgery.

    iii. Upon Mrs Quinn's discharge to Richmond House she continued to be prescribed Dalteparin, which is administered by way of an injection, and was discharged with sufficient injections to complete the course on the 18th June 2015. The hospital notes which accompanied her discharge detailing instructions to the Nursing Home regarding her medication however, indicated that Dalteparin should be administered until the 11th June 2015. As a result Dalteparin was stopped on the 11th June 2015.

    iv. The Deputy Manager of Richmond House gave evidence that there were a number of injections left over on the 11th June 2015 which had been sent from the Hospital, but no action was taken in relation to the excess medication. He confirmed that the Home did not contact the Hospital to enquire why there were extra doses of the medication, and stated that in his experience there have been other occasions where residents at the Home had extra doses of medication left after the course prescribed

	had been completed. v. Evidence given by the Consultant Histopathologist at the inquest confirmed that the sub-optimal deep venous thrombosis prophylaxis was a contributory factor in Mrs Quinn's death. vi. Evidence was given that there had been a review undertaken by the Royal Bolton Hospital following Mrs Quinn's death, which identified that Dalteparin should have been given on the 21st May 2015 and should have continued until the 18th June 2015. Their review found that the notes provided to the Home had been inaccurate. As a result of that review action has been taken to prevent this occurring again. 2. I have concerns with regard to the following: i. The management of the medication for the residents at Richmond House Nursing Home. ii. Evidence was given at the Inquest that there are occasions where Richmond House Nursing Home are left with excess medication than is prescribed to, or directed to be taken by, a resident in their care. This medication should be accounted for and should therefore be queried as residents may not be given medication in circumstances where they should be. I therefore request that Richmond House Nursing Home, which is governed by HC-One Limited, review their policies and procedures regarding the management of the medication prescribed to their residents.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation 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, 28th December 2015. 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) Mrs Quinn's son, Stephen Quinn



	(2) The Chief Executive of The Royal Bolton Hospital, Minerva Road, Farnworth, Bolton (3) Wigan Borough Clinical Commissioning Group, Wigan Life Centre, College Avenue, Wigan, WN1 1NJ (4) Mrs Donna Hall, Chief Executive, Wigan Council, Town Hall, Library Street, Wigan, WN1 1YN 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** **2nd November 2015**	**Signed** **Rachael C Griffin**