	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Senior Partner, Northfield Medical Practice, Blaby. The Senior Partner, Hazelmere Medical Centre, Blaby. **Mr Tim Sacks, Chief Operating Officer, East Leicestershire and Rutland CCG**
1	**CORONER** I am Lydia Brown, Assistant Coroner for Leicester (City and South)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 04/08/2016 I commenced an investigation into the death of Francis James Lea, 89, called Jim. The Inquest concluded on 01 December 2016. The conclusion of the inquest was Narrative. Jim died on 25 July 2016 in Leicester Royal Infirmary following admission 1 week earlier in status epilepticus. At the time he was not taking prescribed anti-epileptic medication. The appropriate medication had been prescribed following a previous hospital admission in April: Jim also presented on that occasion with a seizure. Jim's general practitioner had been changed without appropriately recording this information in the home's "hospital pack" or advising his family, thus allowing the discharge letter to be sent erroneously to the previous GP. Attempts to notify the new GP were unsuccessful, and so the hospital medication finished and no new medication was received. On a balance of probabilities, this caused Jim's death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Lea was in a care home and a decision was made to transfer him from his own General Practitioner of some 10 years to a new GP. The rationale for this decision was to ensure that all the residents had the same GP practise for ease of managing their care. The evidence at inquest was that at no stage were Mr Lea's family involved with or alerted to this change. Very shortly after the transfer took place on 19 April 2016 Mr Lea was admitted to hospital with a seizure and on discharge he was prescribed anti-epileptic medication with the intention this would be continued for life. In fact, the medication stopped after the hospital supply ended as his new GP was unaware of the hospital admission and unaware that he required this medication. The discharge letter had been sent by the hospital to the previous GP. The family had accompanied Mr Lea to hospital and had confirmed the old GP details, having no knowledge of the change. The home failed to supply the new GP details in the "hospital pack" as this had not been updated, and for reasons that could not be established at inquest, their efforts to alert the new GP to the discharge letter and new medications were unsuccessful.

Town Hall Square, Leicester, LE1 9BG
Tel 0116 4541030 | Fax 0116 225 2537

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) For a patient in a care situation, with declining cognitive function (as set out in his home care plan) it would seem appropriate to consider involving the next of kin in any significant decision such as change of GP. This would have enabled the family (who always ensured they accompanied Mr Lea for any medical care) to pass on the updated information, and this outcome would have been avoided. (2) There appeared to be no notes on the patient's medical record regarding the rationale for this change, or any consent from the patient that he was in agreement that it should take place. There was also no record of whether any consideration of his capacity had been undertaken, and if so what the outcome of that decision was. (3) Given this was a joint decision between the GP surgeries and the care home, it would seem that each surgery should share responsibility for a safe and effective transfer of care and therefore this report is being sent to each surgery for further consideration and the CCG.

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 Thursday 9th February 2016. 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] (Family) The Manager, Whetstone Grange Care Home. **Mr J Adler, Chief Executive, University Hospitals of Leicester NHS Trust** 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 15th December 2016 Signature_____ for Leicester (City and South)

Town Hall Square, Leicester, LE1 9BG
Tel 0116 4541030 | Fax 0116 225 2537