REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Senior Partner Fitzalan Medical Group Fitzalan Road Littlehampton West Sussex BN17 5JR 2. NHS Coastal West Sussex Clincal Commissioning Group The Causeway Goring-by-Sea West Sussex, BN12 6BT
1	**CORONER** I am Karen Harrold, Assistant Coroner for the coroner area of West Sussex.
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 http://www.legislation.gov.uk/uksi/2013/1629/made
3	**INVESTIGATION and INQUEST** On 19th July 2017 the Senior Coroner, Penny Schofield, commenced an investigation into the death of David Edward Jackson aged 76 years old. The investigation concluded at the end of the inquest on 17th October 2017. I recorded a conclusion of Accidental Death and the medical cause of death as: 1a) Severe pressure sores associated with sepsis, toxaemia & rhabdomyolysis; 1b) Prolonged immobility following a fall and dislocation of the hip; 2) Hypertensive and ischaemic heart disease.
4	**CIRCUMSTANCES OF THE DEATH** David JACKSON was a 76 year old man who lived with his wife [redacted] in their ground floor flat in Littlehampton. On 17th July 2017 an ambulance was called to his home as he was found by his wife unresponsive on the floor. A paramedic attended and confirmed his death at 05:10 hrs. [redacted] has some mobility difficulties and repetitive strain to her wrists. As a result, she used the furniture to move around the flat. She states that her husband also used a walking stick or crutches to move around the house following a fall at home about 3 years ago when he injured his feet and also had an old back injury. Mr Jackson had not seen a Doctor for over 10 years and had not left the flat for at least 3 years. He had some prescription medications including butobarbitol to help him sleep and co-dydramol for pain relief and had done so for many years. He had last seen a GP in August 2013. [redacted] would collect her husband's prescriptions and take them to the chemist, and when she could, she would get shopping in. More recently she would give a

shopping list to a neighbour and friend, [redacted], who lived in the flat upstairs and he would get the shopping for her. He would bring it back and pass it to [redacted] at the door. He never entered the flat and had not seen Mr Jackson for a long while, although he often heard him calling or shouting at [redacted]

David Jackson spent most of his time on the sofa in the lounge. [redacted] later told police that on 2nd July 2017, her husband called out to her and went she went to him he was on the floor of the lounge. He was slumped down lying on his left side. He told her he had been reaching for the TV control or TV Times when his sight went black and he fell to the floor. She tried to help him up but was unable to do so because of her own difficulties. Mr Jackson refused to allow her to call for help or assistance or for an ambulance. He did not want a Doctor and would not let her ring anyone. He said he would not go to hospital. She told him he could not stay there and she could not leave him there. He still refused to allow her to call anyone. He remained on the floor where he was, in the position he was when he fell, for 2 weeks.

[redacted] looked after him as best she could. She tried to persuade him to change his mind, but he would not. She gave him what food she could such as soup or custard, but explained that because of the position he was in, his mouth was on his arm and it was hard to feed him. He did not, or could not change his position on the floor. She gave him a bottle to urinate in and she removed his soiled clothes. She could not re-dress him however. She had given him pillows and covered him up. She noted he had sores developing and she tried to treat them with Savlon and covering them with sanitary towels, and tried to keep them clean. The sores began weeping and were on his sides, his arms and his knees. He complained the sores were hurting but could not change his position, and nor could she.

As Mr Jackson's condition deteriorated he was increasingly asleep most of the day. [redacted] had been sleeping on the sofa to keep an eye on him, since he fell. She went to sleep at about 2230hrs on 16th July. At about 04:15hrs on17th July 2017, she checked on him and noted that he was not moving and appeared not to be breathing. She dialled for an ambulance at 04:57hrs and an ambulance arrived at 05:05hrs. Recognition of his death was recorded at 05:10hrs by paramedics.

The Police were called to attend the location due to the unusual circumstances as well as a Coroner's Officer. [redacted] was relocated to a care home where she was later spoken to by police and her statement obtained. It was noted that the flat they lived in was in a very poor state of repair and not habitable.

The Police investigation confirms that there were no suspicious circumstances and no action is being taken in respect of Mr Jackson's death.

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.

I heard evidence from [redacted] after considering Mr Jackson's patient record that he was registered as a patient at the Fitzalan Medical Group under the NHS Coastal West Sussex CCG on 26 May 1993. At that stage he was prescribed by [redacted] Sodium Amytal capsules and Co-proxamol tablets.

Records also show that Mr Jackson remained on Co-proxamol until 25 Feb 2005 when [redacted] prescribed a repeat issue of of Co-dydramol instead. Mr Jackson remained on Co-dydramol until his death on 17th July 2017, some 12 years.

On 18 Oct 2007, Dr McLeod saw Mr Jackson to review his prescription for Sodium Amytal as the pharmacy had flagged in Aug 2007 that this drug was only prescribable on a named patient basis and was unlicensed. Records also confirmed that [redacted]

continued to prescribe Sodium Amytal until Soneryl (butobarbitol) was first noted on 30 June 2009 although there is no mention of a discussion with the patient. Mr Jackson again remained on this drug until his death in July 2017, namely 8 years.

[redacted] also confirmed that working from records it seemed the last time Mr Jackson was seen by a doctor face to face was on 18 October 2007. She gave evidence that [redacted] would have advised the patient of the risks associated with the type of medication he was being prescribed.

Over the next 10 years, the records note a medication review was conducted by [redacted] on 21 Oct 2008 and 2 March 2010 but on the records alone. There is one entry on the patient record for [redacted] on 23 November 2015 noting only '*medication review done*'. When giving evidence, [redacted] indicated that when [redacted] retired in 2015 she took over Mr Jackson as a patient but she had never actually seen him. Her recollection was that she had conducted annual medication reviews by considering the patient's past history but only one is noted on the record printout.

GMC good practice guidance was discussed with [redacted] as follows:

- Good medical practice (2013) – para 16: *In providing clinical care you must prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health, and are satisfied that the drugs or treatment serve the patient's needs*; and,

- Prescribing and Managing Medicines (2013) – paragraphs 51; 54; 55; 56; 59
  - *51: Whether you prescribe with repeats or on a oneoff basis, you must make sure that suitable arrangements are in place for monitoring, followup and review, taking account of the patients' needs and any risks arising from the medicines.*
  - *54: Pharmacists can help improve safety, efficacy and adherence in medicines use, for example by advising patients about their medicines*
  - *and carrying out medicines reviews. This does not relieve you of your duty to ensure that your prescribing and medicines management is appropriate…*
  - *55: You are responsible for any prescription you sign, including repeat prescriptions for medicines initiated by colleagues, so you must make sure that any repeat prescription you sign is safe and appropriate. You should consider the benefits of prescribing with repeats to reduce the need for repeat prescribing.*
  - *56: As with any prescription, you should agree with the patient what medicines are appropriate and how their condition will be managed, including a date for review. You should make clear why regular reviews are important and explain to the patient what they should do if they:*
    a) suffer side effects or adverse reactions, or
    b) stop taking the medicines before the agreed review date (or a set number of repeats have been issued), You must make clear records of these discussions and your reasons for repeat prescribing.
  - *59: When you issue repeat prescriptions or prescribe with repeats, you should make sure that procedures are in place to monitor whether the medicine is still safe and necessary for the patient. You should keep a record of dispensers who hold original repeat dispensing prescriptions so that you can contact them if necessary.*

http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp

The MATTERS OF CONCERN are as follows. –

1. When asked about current practice in relation to issuing prescriptions for drugs such as Soneryl or Co-drydamol [redacted] acknowledged that national guidance had tightened up particularly in respect of issuing prescriptions to patients for opiate based drugs. She accepted that medical thinking had moved on considerably. She was candid and accepted that in respect of Mr Jackson he had not been seen for 10

	years and must have fallen through the cracks in terms of medication reviews including a period when the surgery had a shortage of doctors. This suggests a need to review: a. how and when medication reviews are carried out in the Fitzalan Medical Group; b. a potential training need for group doctors in GMC good practice; or, c. the development of a local CCG/Group policy. 2. [redacted] was also asked how were repeat prescriptions requested, collected or delivered. She was unable to help me in Mr Jackson's case but referred to a potential patient advocate, I believe meaning the person who he nominated to collect his prescription. In this case for some time that was [redacted] but given her increasing immobility this may have been a neighbour. [redacted] also referred to working with local pharmacists but the details were unclear. This again suggests a need to review: a. the period of time that Mr Jackson remained on repeat prescriptions without being seen; b. the unknown arrangements for collection or delivery; and c. possibly the arrangements with local pharmacies.
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 19th December 2017. 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] 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	**Date: 24th October 2017** Karen Harrold Karen Harrold Assistant Coroner West Sussex