IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Margaret Jean Silver
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: Suzanne Rankin Chief Executive Ashford and St. Peter's Hospitals NHS Foundation Trust St. Peter's Hospital Guildford Road Chertsey Surrey KT16 0PZ
1	**CORONER** Ms Anna Crawford, HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** An inquest into the death of **Margaret Silver** was opened on 4 March 2016. It was resumed on 28 November 2017 and concluded on 30 November 2017. The medical cause of death was recorded as: 1a. Aspiration Pneumonia 1b. Fractured Left femur II. Old Pulmonary Emboli, Frailty, Osteoporosis, Hypertensive Heart Disease, Chronic Obstructive Pulmonary Disease. The inquest concluded with a narrative conclusion, covering the matters set out below.

4	**CIRCUMSTANCES OF THE DEATH** Mrs Silver was an 85 year old lady who resided at West Hall Care Home in West Byfleet. On 12-15 November 2015 she was admitted to St Peter's Hospital where she was diagnosed with a deep vein thrombosis. As a result, she was prescribed Rivaroxaban, (an anti-coagulant) for life. However, the Discharge Summary contained contradictory information in relation to the prescription, stating both that it should continue for 21 days and then stop and also that it should continue for life. The inconsistency was not noticed either by Mrs Silver's GP or the staff at her care home, and as a result, the Rivaroxaban was discontinued on 6 December 2015. Mrs Silver attended St Peter's Hospital on 1, 12 and 13 January 2016 and on none of those occasions was the lack of Rivaroxaban identified or acted upon by the hospital, despite Mrs Silver telling hospital staff on 12 January 2016 that she thought that she was no longer taking it. Mrs Silver was then readmitted to St Peter's Hospital from 26 January 2016 to 4 February 2016, at which point she was diagnosed with extensive bilateral Pulmonary Emboli and restarted on Rivaroxaban. Prior to her discharge on 3 February 2016, her mobility was noted to have decreased and the Occupational Therapist recorded that she would require the use of a commode on her return to the care home. It has not been possible to establish whether or not this information was passed on to the care home. On her return to the care home Mrs Silver presented with reduced mobility and on both 5 and 6 February 2016 it is recorded that she struggled to bear her own weight on being assisted to the toilet. However, no changes to her care plan were introduced and she was not provided with a commode. Information regarding her recent hospital admission and reduced mobility was not passed on to the carers assisting her on 7 February 2016. On 7 February 2016 Mrs Silver sustained an assisted fall whilst attempting to transfer from the toilet to her wheelchair, sustaining a fractured left femur. The court found that the fall resulted from her general frailty, which was in part contributed to by the development of the pulmonary emboli.

	Following the fall she was readmitted to St Peter's Hospital. She developed a chest infection on 19 February 2016 and underwent surgery on 22 February 2016. Her condition deteriorated and she died at the hospital on 25 February 2016.

5	**CORONER'S CONCERNS** The Discharge Summary contained contradictory information in relation to the future prescription of inpatient medication, which led to the medication being discontinued after 21 days when the intention was that it be taken for life. The fact that the Rivaroxaban had been discontinued was not identified by clinicians at St Peter's Hospital, despite Mrs Silver attending the hospital on three occasions since her Rivaroxaban had been discontinued, and despite her informing them on 12 January 2016 that she thought it had been discontinued. Mrs Silver was not provided with the equipment and support which had been recommend by the Occupational Therapist prior to her discharge on 3 February 2016. It was not possible to establish whether the information had in fact been passed on to the care home. The **MATTERS OF CONCERN** are: - Current procedures may result in inaccurate or contradictory information about prescribed medication being included in hospital discharge summaries. - The procedures in place for recording a patient's medication on admission to, and discharge from, hospital may fail to identify circumstances in which a patient is no longer in receipt of potentially life-saving medication. - The procedures in place for discharge planning may fail to ensure that occupational therapists' recommendations regarding necessary support and equipment are not passed on to those caring for patients in the community. Consideration should be given to whether any steps can be taken to address the above concerns.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following: 1. [redacted] 2. West Hall Care Home 3. [redacted], Heathcot Medical Practice, Woking 4. Care Quality Commission 5. The Chief Coroner In addition to this report, I am 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.
	Signed: **ANNA CRAWFORD** **DATED this 3rd Day of January 2018**