The Leeds Teaching Hospitals NHS
NHS Trust

Date: 22 October 2018
Our ref: YO/bb

Mr P Holden
Assistant Coroner
West Yorkshire (Eastern)
Coroner's Office and Court
71 Northgate
Wakefield WF1 3BS

24 OCT 2018

[redacted]

www.leedsth.nhs.uk

Dear Sir 4173 | 17 | CF | LC INQ. 22.8.18

Inquest touching the death of Michael John DREWELL

I refer to your correspondence of 30th August 2018, received on 31st August regarding the inquest touching the death of Michael John Drewell and the Regulation 28 Report to Prevent Future Deaths in respect of this case. Your letter has been forwarded on for me as Chief Medical Officer for the Trust to respond to.

I can confirm that the contents of your Regulation 28 Report have been shared with the relevant staff to enable us to provide you with a comprehensive response.

In your report you highlight that your matters of concern are:
(1) The treating consultant advised that Mr Drewell, because of his height and weight, be given the anticoagulant Tinzaparin for six weeks rather than four weeks as was usual. He recorded his advice on the handwritten records at hospital following a ward round the day after surgery. When the junior doctor came to prescribe Tinzaparin several days later he did not consult the handwritten notes and only prescribed four weeks Tinzaparin immediately before Mr Drewell's discharge from hospital.
(2) The advice of a senior clinician was not followed and, further, that his advice was not placed upon the electronic notes.

The team has considered the contents of your correspondence very carefully and the responses to the matters of concern you have raised in the report are detailed below.

The clinical team have advised me that Mr Drewell was a 57-year-old gentleman who fell from his bicycle whilst travelling to work on 16th November 2017. He attended Leeds General Infirmary and was diagnosed with a displaced fracture of his right hip. On the day following surgery, the orthopaedic consultant advised that Mr

Drewell take Tinzaparin for six weeks to reduce the risk of deep vein thrombosis. He was discharged on 22nd November and was provided instead with a four week course of Tinzaparin, a prescription given in accordance with NICE guidance.

On 22nd December 2017 Mr Drewell suffered a cardiac arrest at home and paramedics were unable to resuscitate him. He was pronounced dead at 23.55 that day. A post-mortem examination revealed that Mr Drewell had suffered a pulmonary embolism. The course of Tinzaparin had stopped two days prior to Mr Drewell's collapse.

At the inquest it was accepted that it was not possible to say that the ending of the prescription more than minimally contributed to his death. The Trust provided a root cause analysis summary that concluded that the correct dose of Tinzaparin had been prescribed for a gentleman of Mr Drewell's height and weight and that there had been no lapses in care. Tinzaparin was prescribed at discharge according to NICE guidance. The trust has therefore determined that, notwithstanding the request by an individual consultant, Tinzaparin was correctly prescribed for Mr Drewell and it is not possible to say that a longer course of the anticoagulant would have prevented his death.

In your Regulation 28 Report you highlight the fact that the junior doctor did not consult the hand-written medical records before prescribing the discharge medication. I am sure that you will agree that it is impractical for junior doctors to comprehensively review the medical record in its entirety when completing the electronic discharge advice note (EDAN) and prescription. It is therefore imperative that if individual clinicians decide to prescribe 'off protocol' they either action this themselves personally, or leave clear unambiguous instructions within the electronic record. This can be done in two ways; either the eMeds electronic prescribing chart can be annotated or the EDAN can be pre-populated with specific discharge advice. It is regrettable that neither of these were done on this occasion and I have written to the Clinical Directors and asked that they remind all clinicians about the importance of robust handover and communication.

I can reassure you that good practice is already embedded within many clinical areas throughout the Trust. For example, Elderly Medicine patients with pelvic fractures who are being discharged to care in the community (CIC) beds have Tinzaparin continued until they are weight bearing after discharge. An instruction to this effect is added to the electronic drug chart and this information is then pulled through automatically to the EDAN. In addition, our pharmacists will also add electronic notes regarding discharge medication advice following multi-disciplinary team meetings with treating clinicians.

Thank you for bringing these matters to my attention. I do hope that this response has assured you that the Trust has given careful consideration to the matters of

concern you have raised. If I can be of any further assistance please do not hesitate to contact me.

Kind regards.

Yours sincerely,

[redacted]
Chief Medical Officer
Leeds Teaching Hospitals NHS Trust