ANNEX A

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. Chief Executive of Nottinghamshire University Hospitals NHS Trust**
1	**CORONER** I am Jane Gillespie, assistant coroner, for the coroner area of Nottinghamshire
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 03.10.2018 I commenced an investigation into the death of Malcolm John Lupton Rathmell, aged 79. The investigation concluded at the end of the inquest on 08.02.19. The conclusion of the inquest was a narrative conclusion; On the 2nd day of April 2018 Malcolm Rathmell died of bronchopneumonia developed as a result of a prolonged period of immobility. This was the result of a hip fracture sustained two days prior to Mr Rathmell's admission to the Queens Medical Centre on 14th March 2018, which was not diagnosed until 20th March 2018. Whilst in hospital Mr Rathmell was incorrectly prescribed warfarin on 4 or 5 occasions between 14th and 20th March 2018 when another's patient's anti-coagulation chart was incorrectly labelled with Mr Rathmell's name. This led to a significant retroperitoneal bleed which contributed to Mr Rathmell's death at the Queens Medical Centre, together with his past medical history of chronic kidney disease and hypertensive heart disease.
4	**CIRCUMSTANCES OF THE DEATH**

	Malcolm Rathmell was admitted to the Emergency Department at Queens Medical Centre on 14.03.18 following a fall at home two days previously. He was complaining of right hip pain. He was transferred to ward B3 at approximately 9.30pm the same day. An x-ray of his hip and chest had not revealed any fracture and the working diagnosis was a collapse of unknown cause and muscular pain. In the days that followed, it was considered that Mr Rathmell's pain was disproportionate to the diagnosis and he was sent for an MRI which was delayed. On 20.03.18 it was confirmed that he had a fracture of the right pubis and right inferior pubic ramis. Also on ward B3 was another patient, who will be referred to as Patient B. Patient B had been admitted due to acute delirium and had a history of atrial fibrillation. He required warfarin and an anti-coagulation chart had been created for Patient B. At some point after Patient B's chart was created at 10.10pm on 14.03.18, the chart was labelled with Mr Rathmell's name and details. As a result, between 14.03.18 and 20.03.18 Mr Rathmell incorrectly and unnecessarily received 4 or 5 doses of warfarin. This was not identified by any of the multi-disciplinary team involved with Mr Rathmell until a pharmacy check on 22.03.18 revealed the mistake. Mr Rathmell started to suffer from retro-peritoneal bleeds on 25.03.18 and this continued until 27.03.18. Mr Rathmell passed away on 02.04.18. The cause of death was: 1a. Bronchopneumonia 1b. Pelvic fracture 2 Chronic kidney disease, hypertensive heart disease, retroperitoneal haemorrhage [redacted], Pathologist gave oral evidence and stated that he could find no origin for the bleed during the post mortem examination, and the haemorrhage was therefore likely spontaneous, due to a rupture without evidence of trauma and therefore, on the balance of probabilities, this indicated that the bleed was due to the warfarin treatment. I found, therefore, that the unnecessary warfarin treatment contributed to Mr Rathmell'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 could 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) Mr Rathmell was treated and reviewed by a number of medical professionals from various disciplines between 14.03.18 and 22.03.18. No one identified during that time that he was being prescribed warfarin incorrectly. (2) It has not been possible to identify when Patient B's anti-coagulation chart was labeled with Mr Rathmell's details, save that it is likely, on the balance of probabilities, that it took place on ward B3 between 1.30pm on 15.03.18 and 4.06am on 16.03.18. (3) It has not been possible to establish how or why this happened despite an extensive investigation by the Trust and a detailed enquiry during the inquest. (4) There was no ward based pharmacy review between 15.03.18 and 22.03.18. (5) The proposed actions being considered by the Trust to address the issue of incorrect prescribing are in their infancy and other than sharing the learning from the SI report, no other changes or action has been implemented to address the risk of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion 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, namely by 17.04.19. 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] – Mr Rathmell's sons Health Safety Investigation Branch (HSIB) 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	 **Miss Jane Gillespie** **Assistant Coroner for Nottingham and Nottinghamshire** **20.02.2019**