	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Dr P Hughes, Medical Director, Legal Department, Level 07, Derriford Hospital, Plymouth, PL6 8DH**
1	**CORONER** I am Andrew James Cox, Assistant Coroner for Plymouth Torbay and South Devon.
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 22 September 2017, I commenced an investigation into the death of Terence Douglas Thornton,then aged 82. The investigation concluded at the end of the Inquest on 3 April 2019. The conclusion of the Inquest was that Mr Thornton died as the result of an accident to which a known complication of necessary medical treatment contributed. The medical cause of death was given as:_ 1(a) Acute Subdural Haematoma 1(b) Fall 1(c) Postural Hypotension II Warfarin Therapy or Deep-Vein Thrombosis
4	**CIRCUMSTANCES OF THE DEATH** On 16 September 2017, Mr Thornton was admitted into Derriford Hospital following a fall in which he struck his head. He was receiving warfarin for previous DVTs. A CT of his head was reported as being normal. (In fact, a subsequent review identified a subtle, small subdural haemorrhage.) On 17 September 2017, Mr Thornton was discharged to Liskeard Community Hospital arriving at approximately 18:50 hours. At approximately 19:00 hours on 18 September 2017, Mr Thornton was given a dose of enoxaparin. At 07:30 hours on 19 September 2017, he was found comatose in bed. He was taken to Derriford Hospital where a further CT scan revealed a catastrophic expansion of the earlier (missed) subdural haemorrhage. Mr Thornton deteriorated and died in Derriford on 19 September 2017.
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. – BRIEF SUMMARY OF MATTERS OF CONCERN (1) During the course of the Inquest, I heard evidence from [redacted] at Liskeard community hospital. She gave evidence that when Mr Thornton was admitted from Derriford, he arrived without an E-discharge, a copy of his prescription chart or his prescribed medication. As he was admitted during a Sunday evening where there was no medical cover in the hospital, this created very real difficulties. The out of hours service had to be contacted for a doctor to attend. In the event, that Doctor refused to prescribe blood thinning medication and Mr Thornton did not receive any for nearly 24 hours notwithstanding his known history of DVTs. [redacted] told me that this "happens frequently."

	(2) I also heard from Doctor Sant. He works in Liskeard hospital on Mondays and Fridays. On Mondays, he deals with patients who have had been admitted from Derriford over the course of the weekend. He told me in evidence that his "guess" was that between 5 – 10% of patients do not arrive with the correct paperwork or medication. He agreed with my suggestion that if this was allowed to continue it would inevitably result in the future with a patient suffering harm. (3) I would be grateful if you would consider the process for discharging patients from Derriford to Liskeard community hospital particularly where that discharge occurs out of hours, on a Friday (before the weekend) or over the course of a weekend. You may feel that there is a need to ensure the process is more robust and that patients are not discharged without any of the e-discharge form, a copy of the prescription chart and any prescribed medication. You may feel that it would be sensible to audit compliance with these requirements to ensure that an efficient and effective discharge to a community hospital takes place.
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 1 June 2019. 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] Director of Nursing at Cornwall Partnership Foundation 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 **3 April 2019** Signature_____ **Andrew Cox, Assistant Coroner, for Plymouth Torbay and South Devon**

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