REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Registered Manager Beechdale Medical Group**
1	**CORONER** I am Dr Elizabeth Didcock, 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 the 8th January 2019, I commenced an investigation into the death of Evelyn Ann Swift. The investigation concluded at the end of the inquest on 15th August 2019. The conclusion of the inquest was a narrative conclusion as follows: Evelyn Ann Swift died at her home address in Nottingham, on 4th January 2019, at the age of seventy five, from pneumonia. She also had Ischaemic heart disease that made a contribution to her death. The assessment of her condition on the previous day was incomplete and underestimated the severity of her symptoms, such that a hospital admission was not arranged. This was a missed opportunity to arrange appropriate medical care. It is not possible to say whether or not she would have survived had she been admitted on 3rd January 2019.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Swift (Ann) was known to have Chronic Obstructive Pulmonary Disease, and was on inhaler treatment. She became unwell over the few days prior to her death, and contacted the GP surgery on 3rd January 2019 to request a home visit. The home visit was not arranged until the evening of 3rd January 2019, by which time Ann had rung on five occasions, and was more unwell. The home visit was completed by a nurse from the Practice. She did not have the full information regarding Ann's past medical history nor treatment, nor the knowledge that Ann had contacted the surgery frequently during the day. The clinical assessment made during the home visit was incomplete and the severity of her condition not recognised. She was not admitted to hospital and was found deceased the following morning at her home address. Further detail regarding the circumstances of Ann's death are described in the attached judgment.
5	**<u>CORONER'S CONCERNS</u>** 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. – 1. The Beechdale Medical Group did not have safe procedures in place to triage patients when they presented as unwell.

	2. The Beechdale group did not have safe procedures in place for the allocation of homevisits. 3. The Beechdale group did not have an allocated clinician available each day that was accessible by the Practice team, and available to provide urgent clinical advice 4. The Beechdale Medical Group did not have safe processes in place to ensure that all calls from patients were documented, nor safe processes to ensure that contemporaneous notes made during a home visit were recorded on the patient record. 5. The Beechdale Group did not have sufficient clinical capacity to ensure safe clinical cover arrangements at each location where services are provided. 6. The Beechdale group did not have processes in place to review a significant event, such as a sudden death when there was Practice involvement on the day prior to the death, with no understanding of the need to review and learn as a Practice from such events.
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 the 25th October 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], daughter of Mrs Evelyn Ann Swift I have also sent a copy to the Care Quality Commission for their information. 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	**29th August 2019** **Dr E A Didcock**