Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. Ms Jackie Bligh – Chief Executive, Worthing Homes, Davison House, North Street, Worthing, BN11 1ER
2. Mr Phillip Astle - Chief Executive, South East Coast Ambulance Service, Nexus House, 4 Gatwick Road, Crawley, RH10 9BG
3. Mr Tim Barclay – Chief Executive, Appello, Wylie House, Unit 740, Ampress Lane, Lymington, Hampshire, SO41 8LW
4. Ms Sarah Wilkinson – Chief Executive, NHS Pathways & NHS Digital, 1 Trevelyan Square, Boar Lane, Leeds, LS1 6AE
5. [redacted] – Chair, Association of Ambulance Chief Executives, MBF, GG322, 30 Great Guildford Street, London, SE1 0HS

1 CORONER

I am Robert SIMPSON, Assistant Coroner for the area of West Sussex Coroner's Service

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 04 February 2019 I commenced an investigation into the death of John Michael WELLS aged 73. The investigation concluded at the end of the inquest on 31 October 2019. The conclusion of the inquest was accidental death.

4 CIRCUMSTANCES OF THE DEATH

Mr Wells lived in sheltered accommodation provided by Worthing Homes. Information received from his GP practice revealed that he had been diagnosed with polycythaemia in 2008 and received replacement aortic valves in 2012. He was formally diagnosed with learning difficulties in 2012, dementia in Alzheimer's & moderate frailty both in 2018. He was prescribed rivaroxaban and aspirin amongst other medications.

On the 29th January 2019 Mr Wells lacerated a varicose vein on his leg. He started bleeding and at 05.45 activated his careline which was answered by an Appello operator. Mr Wells informed the operator that his leg was bleeding and that he couldn't stop it. He used the word 'running' repeatedly but was unable to answer specific questions regarding the amount of blood lost.

The Appello operator called 999 Ambulance at 05.48 and informed the South East Coast Ambulance Service (SECAMB) Emergency Medical Advisor (EMA) that Mr Wells was bleeding, he used the word 'flowing' and noted that Mr Wells was quite confused. He informed the operator that Mr Wells had a pacemaker, was on beta blockers, had anxiety, regularly got the shakes and was diagnosed with polycythaemia. The EMA stated that an emergency ambulance was arranged but that due to a high volume of calls they would aim to check back with Mr Wells within the next 2 hours. The Appello operator queried the time frame by saying 'Oh, even

though he is bleeding alot?'

The SECAMB Serious Incident Report (SIR) found that the EMA had not followed procedure. The case was not referred to a clinician as a result of missed clinical cues.

A SECAMB paramedic arrived at Mr Wells accommodation at 07.10am and discovered him sat on the bathroom floor surrounded by a large amount of blood and clots. Mr Wells was in pulseless electrical activity and despite the efforts of the paramedic and further healthcare practitioners he could not be revived and sadly died at the scene.

The medical cause of death was cardiac failure due to decompensated valvular heart disease and severe coronary artery disease. The pathologist's evidence was that the death undoubtedly occurred as result of severe blood loss which itself was a consequence of the anti-coagulant drugs prescribed for the management of prosthetic aortic valves.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:
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 information regarding Mr Wells' medical conditions and medication held by RedAssure/Worthing Homes was not complete.

RedAssure were the providers of the telecare service to Mr Wells and were part of Worthing Homes. RedAssure had contracted Apello to answer out of hours calls.

During the inquest I heard evidence that when a resident moves into Worthing Homes sheltered housing they are asked to provide medical information; as are any persons who happen to accompany them. I heard that updates are requested from the residents by sending out a form.

Neither Worthing Homes nor RedAssure seek permission from the residents to obtain medical information from their GP or other third parties.

I heard evidence that the staff at Worthing Homes had been aware of Mr Wells' special needs and vulnerability but this did not appear on the resident information sheet; which provides the information accessed by Apello.

Whilst I heard evidence that Worthing Homes are no longer providing telecare support they still provide the medical information recorded on their residents to telecare providers.

Subsequent to the inquest Worthing Homes provided further information to assist with the preparation of this report. This confirmed that RedAssure no longer existed and that Worthing Homes, as a social housing provider, were not involved in providing care or medical assistance. They state that medical information gathered at the application stage is solely for the purpose of ascertaining the prospective resident's suitability for a property.

Worthing Homes provided a full version of a review record from 2015 clearly stating that Mr Wells had learning difficulties. In addition a GP letter provided to Worthing Homes in 2008 states that Mr Wells had a low IQ. Neither of these pieces of information were transferred on the front sheet of the record, which appears to have been the source of the information entered onto Carenet.

As a result of the incomplete records and summary Appello & SECAMB were not provided with important and accurate information regarding Mr Wells.

(2) The telephone numbers for the RedAssure responders are not contained within the Appello call handling system (Carenet).

Under the contract between RedAssure and Appello the operator should have called a responder once he had spoken to SECAMB. The operator phoned telephone numbers from the 'listed contacts' screen and believed that this included a responder. It did not.

The RedAssure responders' contact details are accessed via a separate policy document that the operator needs to open. No link to these numbers is provided from Carenet nor are they listed in the 'contacts' section of Carenet.

(3) There is no mechanism for the automatic flagging of risks related to particular medical conditions or medications within Carenet.

I heard evidence that Appello operators are not medically trained and are employed to handle a wide variety of of calls. There is no system in place highlighting risk factors which might allow the operators to respond more appropriately to medical emergencies and ensure that they pass the most important information to the emergency services.

(4) Under NHS Pathways triage system ambulance calls received from third party callers are handled in a different way from those received from persons present with a patient.

The SECAMB SIR indentified that the receipt of a call from a third party was a contributory factor, partly as it required a first party call back. Mr Wells stated he was not able to talk to the ambulance service on the telephone.

From the evidence before the inquest it was clear that the Appello operator was still connected to Mr Wells when in contact with SECAMB. However there was no way for the operator pass the call though therby allowing direct contact between Mr Wells and the SECAMB EMA.

(5) An early exit from the NHS Pathways Module 0 occurs when a call is received from a third party. Subsequent unanswered calls direct to the patient do not necessarily lead to a clincal review of the triage decision.

From the evidence heard at inquest it was established that the EMA would exit module 0 of NHS Pathways at an early stage when a call received from a third party. All subsequent actions are largely dependant on the EMA correctly identifying the clinical position of the patient and correctly triaging it despite the limited number of questions asked of the caller.

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 February 03, 2020. 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:

The family of Mr John Michael Wells

I have also sent it to the following who may find it useful or of interest:

Ms Alyson Scurfield – Chief Executive Officer, TEC Services Association, Wilmslow House, Grove Way, Wilmsow, Cheshire, SK9 5AG

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.

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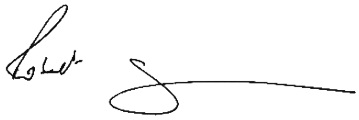

Robert SIMPSON
Assistant Coroner for
West Sussex Coroner's Service
Dated: 09/12/2019