ANDREW JAMES COX
Assistant Coroner for Plymouth Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted] Medical Director, Plymouth Hospitals NHS Trust, Derriford, Plymouth**
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 15/04/2016 I commenced an investigation into the death of Harry Glibbery. The investigation concluded at the end of an Inquest on 15 August 2016. The narrative conclusion of the inquest was that Mr Glibbery died from a known complication (bleeding) of a necessary medical procedure (anti-coagulation)
4	**CIRCUMSTANCES OF THE DEATH** Mr Glibbery suffered with a chronically infected left total hip replacement. He was under the care of [redacted] Consultant Orthopaedic Surgeon whose efforts were greatly appreciated by the family. Mr Glibbery had a number of wash-outs as well as two first-stage revisions. On 26th February 2016 he underwent a Girdlestone procedure. On 4 March Mr Glibbery complained of shortness of breath and chest pain. A CT PA on 8 March revealed multiple pulmonary embolii as a consequence of which Mr Glibbery was started on Clexane. At Inquest I was advised that the Derriford Protocol provides for patients to be prescribed 1.5 milligrams per 1 kilogram once daily. As a matter of fact, I found that Mr Glibbery was prescribed 1 milligram per kilogram administered twice daily. Upon admission into hospital Mr Glibbery weighed 80 kilograms and, as a consequence, he received 160 milligrams of Clexane daily instead of 120 milligrams. I was advised that the prescription was reviewed on 3 separate occasions by Pharmacy clinicians but the error was not identified. On 5 April Mr Glibbery deteriorated acutely and a CT scan revealed a catastrophic intracerebral haemorrhage from which he died on 7 April 2016. As a matter of fact I found that the over-administration of Clexane did not cause the death but it may have contributed to the outcome in the sense that once the intracerebral haemorrhage started it bled more profusely that would otherwise have been the case.
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. – (1) The doctor who originally prescribed the Clexane did not do so in accordance with Derriford Protocol; (2) The doctor's prescription error was not identified during Pharmacy reviews intended to pick

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	up precisely this sort of shortcoming; (3) I was advised that during Mr Glibbery's admission he lost a substantial amount of weight estimated at between 6 – 10 kilograms. [redacted] (who gave evidence) expressed their difficulties in having patients weighed. This is particularly difficult for patients who have undergone hip replacements where, I was told, a hoist that is available is not high enough to return patients back to their beds. The importance of this is obvious in patients whose medication is weight-dependent. It is believed that Mr Glibbery was on the cusp of requiring a downward review of the amount of Clexane prescribed to him.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Dr. P Hughes 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 10 October 2016. 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] wife of the deceased. 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 16 August 2016 Signature_____ Assistant Coroner for Plymouth Torbay and South Devon