REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

[redacted]
GP Surgery
Parkway Health Centre
Parkway
New Addington
Croydon
Cr0 0JA

1 **CORONER**

I am Miss S. Ormond-Walshe, HM Senior Coroner, South London Jurisdiction.

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 2nd June 2018 I commenced an investigation into the death of Mrs Patricia Mcadam. The investigation concluded at the end of the inquest on 13th March 2020. The medical cause of death was:

1a. Multi-Organ failure
1b. Septic Shock
1c. Infected leg ulcers (with osteomyelitis) and peripheral vascular disease
2. immobility due to rheumatoid arthritis and low body mass index (cachexis)

The conclusion of the inquest was that Patricia Mcadam died suffering sepsis caused by peripheral vascular disease and immobility.

4 **CIRCUMSTANCES OF THE DEATH**

The deceased was known to be wheelchair bound due to her arthritis and was a smoker with peripheral vascular disease. She was cared for at home by her daughter. On 31st May 2018 she was admitted to Croydon University Hospital in a state of extremis. Her pressure sores and leg ulcers were Grade 4. She died of sepsis eleven days later on 11th June 2018. Post mortem examinations have identified old rib fractures, which could have happened with trivial force. There is some evidence that the deceased refused care in the years preceding her state of extremis in May 2018. She was a frail, elderly lady who had not seen her GP for a long time and the District Nurses since 2015. There is a natural causes element to her death, particularly in relation to her arthritis and peripheral vascular disease.

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. –

Mrs McAdam was known to be wheelchair bound due to arthritis and was a smoker with peripheral vascular disease. She was cared for at home by her daughter. She died at Croydon University Hospital on 11th June 2018 from complications associated with infected leg ulcers. She had not been seen by a GP since 13th July 2015. Although there was a large element of the patient herself declining contact and care from healthcare providers, her repeat prescriptions (of Oramorph, co-codamol, Amitriptyline and

Furosemide) continued despite there being no obvious regular attempt, or any, to assess and check up on her.

Caring for patients refusing patient care is obviously challenging. However, I am concerned that there is a system in place in the future to ensure that these patients are regularly assessed, even if that assessment bears no fruit due to a competent patient declining help. I am reassured that the GP practice has put into place a system now whereby these patients do not get forgotten but this report asks for confirmation of such a system.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and 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 10th June 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 family of Mrs Patricia Mcadam

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, 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 15th April 2020

Signed:

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Miss S Ormond-Walshe
HM Senior Coroner