Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Chief Executive Officer** **Queen Elizabeth Hospital** **Gayton Road** **King's Lynn** **Norfolk** **PE30 4ET**
1	**CORONER** I am Yvonne Blake Area Coroner for the coroner area of Norfolk.
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 3 November 2022 I commenced an investigation into the death of Colin Vincent GREENWAY aged 63. The investigation concluded at the end of the inquest on 17 July 2023. **The medical cause of death was:** 1a) Pulmonary Thromboembolism 1b) 1c) 2) **The conclusion of the inquest was:** Mr Colin Greenway was a relatively fit man he was a football referee. he was overweight but active and his only medication was omeprazole. He went to Cyprus with family and 5 members of his family became unwell with gastroenteritis on 11 October. Mr Greenway came back to the U.K. on the 18 October [redacted]. After a few days with no improvement he was persuaded to speak with his GP who advised rest and fluids on the 19th. On 21 October [redacted] took him to a walk in centre who recommended hospital. he was taken to hospital and admitted and treated with IV fluids and antibiotics. A stool sample identified camopylobacter which required specific antibiotics. He was prescribed anticoagulant at half the usual dose despite his risk factors. his blood results improved and on 25 October he was discharged he was eating and drinking. By 28th he was feeling slightly better resting in bed. On 29 October [redacted] came home to find him deceased in bed. At post-mortem he was found to have developed a pulmonary embolus (P.E.).It is not possible to say if the full dose of anticoagulation would have prevented the P.E.
4	**CIRCUMSTANCES OF THE DEATH** Mr Greenway went to Cyprus with his family [redacted] all became ill with a gastroenteritis. Mr Greenway returned home to the U.K. [redacted] on 18 October, he remained unwell with diarrhoea and nausea. He spoke to his GP on 19 October who advised rest and fluids and went with [redacted] to a walk in centre on 21 October who advised him to attend hospital. He was taken to the

	Queen Elizabeth Hospital in King's Lynn and admitted. He was unwell with acute kidney injury and febrile. He was given IV fluids and antibiotics and urine and stool samples sent. The junior doctor clerking him did not use the clerking booklet when performing a VTE assessment which would have guided [redacted] to prescribe 40mg of enoxaparin an anti-coagulant, instead she used the VTE assessment on the electronic prescribing system which is not as detailed as the paper clerking booklet. To prescribe anticoagulants the electronic VTE assessment has to be filled in. Despite Mr Greenway's known risk factors of age, obesity, recent infection and loss of mobility she prescribed a "renal dose" of 20mg of enoxaparin, half the usual dose. Mr Greenway's eGFR (measurement of renal function) was 58 and the dose of anticoagulant is only supposed to be reduced if this measurement is below 30. When spoken to after Mr Greenway's death [redacted] explanation was that [redacted] did this in a excess of caution despite clear guidelines. Mr Greenway remained on this dose for his entire hospital stay. No senior clinician checked this prescription, the consultant who gave evidence assumed the pharmacists would have done a reconciliation. Mr Greenway was discharged and died several days later from a pulmonary embolism. The pharmacy service at weekends at this hospital had been suspended for some time, this consultant was even aware of this. [redacted] said [redacted] was too busy to check individual patients' new prescriptions on [redacted] ward rounds. The pharmacy reconciliation is meant to operate as a fail safe or safety net, it is the Consultant Doctor's responsibility to check what their junior unsupervised doctors do at the weekend when a patient is admitted. This consultant didn't ever speak to this junior doctor about this mis-prescribing or know what action if any had been taken about it. I was informed by a senior nurse that other such drug errors have occurred since Mr Greenway died. Documentation was poor and the TRAINED NURSES are undertaking courses to show them how to complete fluid balance charts which is something I would expect them to already know how to do. The pharmacy service at the hospital is on the Risk register because of a shortage of pharmacists. Whilst the consultants, three saw Mr Greenway, continue refuse to accept responsibility for doctors prescribing this situation continues.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: • Junior doctors incorrect prescribing despite clear guidelines. • VTE assessments not being completed on clerking a patient just on the electronic medicines prescription which is much less detailed. • Consultants stating it is the pharmacists' job to check for errors when there is only a 3 day service by pharmacists to do this and it is intended as a safety net procedure only. • Consultants not accepting that it is their responsibility to monitor what their junior doctors are doing when prescribing new medications for patients. • 3 different consultants seeing the same patient over 3 days, no continuity of care. • Patients at higher risk of an embolus not being monitored correctly or at all after initial clerking.
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 September 12, 2023. 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], Spouse • [redacted], Daughter I have also sent it to: • The Lord Chancellor • The Royal Pharmaceutical Society of Great Britain • The Department of Health • The Care Quality Commission • HSIB • Healthwatch Norfolk who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 18 July 2023** **Yvonne K Blake** **Area Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH