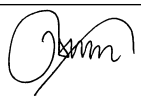
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1. Lincolnshire Integrated Care Board**
	CORONER I am Jayne Wilkes, Area Coroner for the Coroner Area of Greater Lincolnshire
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 31 May 2023 I commenced an investigation into the death of Jonathan Paul SZCZEPANSKI aged 64. The investigation concluded at the end of the inquest on Monday 13 May 2024. The conclusion of the inquest was: **Medical cause of death:** 1(a) Upper Gastrointestinal Haemorrhage 1(b) Duodenal Ulcer 2 Naproxen Treatment **Conclusion** Mr Jonathan Paul Szczepanski died from the consequence of a duodenal ulcer to which the prescription of Naproxen without the corresponding Protein Pump Inhibitor (PPI) made a contribution.
4	**CIRCUMSTANCES OF THE DEATH** (1) Mr Jonathan Paul Szczepanski had a significant medical history which included Parkinson's Disease, Type 2 Diabetes, Hypertension and Spinal Stenosis. (2) He had several repeat prescriptions from his GP surgery to treat his conditions and to provide pain relief. This included Naproxen, a non-steroid anti-inflammatory drug (NSAID) which had been prescribed regularly since 2016 on a dosage level of 500mg twice daily. (3) No corresponding proton pump inhibitor (PPI) medication had ever been prescribed to address the recognised risk of duodenal ulceration from NSAIDs. (4) No medication reviews had taken place to address or manage the risks of long term NSAID prescription, against the background of his relevant co-morbidities. (5) He was admitted to Boston Pilgrim Hospital on 28 April 2024 with an acute kidney injury due to suspected infection and urinary retention. He was discharged on 2 May 2024 with a repeat prescription of Naproxen - 500mg twice daily. No PPI medication was prescribed. (6) He was admitted to Boston Hospital on 14 May 2023 with symptoms indicative of a gastrointestinal bleed. Despite repeated medical and surgical intervention, he did not respond to treatment and his condition was such that further intervention was not possible. (7) He was placed on end-of-life care until he passed away.

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: (1) There is a lack of local practitioner guidance on the practical implementation of the **NICE NSAIDs - prescribing issues documentation**. (2) The software being used to prescribe NSAIDs did not automatically generate a specific warning flag to alert the prescriber to the considerations and risk factors in the prescription of NSAIDs (including the use of PPI). (3) Where repeat prescriptions were issued on discharge of a patient from hospital back to community primary care, there was no warning on the discharge documentation to alert the prescriber to the considerations and risk factors in the prescription of NSAIDs (including the use of PPI).
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 July 12, 2024. 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: (1) [redacted], Welby Group, The New Coningsby Surgery, 20 Silver Street, Coningsby, Lincolnshire, LN4 4SG (2) United Lincolnshire Hospitals NHS Trust 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: 17/05/2024**

	 **Jayne WILKES** **H M Area Coroner for** **Greater Lincolnshire**