

MR G IRVINE
SENIOR CORONER
EAST LONDON CORONERS COURT
124 Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted]National Medical Director, NHS England** [redacted] **2. [redacted] Ministerial Correspondence and Public Enquiries Unit, Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU** [redacted] **3. Maylands Healthcare, 300 Upper Rainham Road, Hornchurch, Essex, RM12 4EQ** [redacted] **4. [redacted]London Medical Director, Practice Plus Group, North West London Integrated Urgent Care Service, Practice Plus Group, Suite South East A&B, 6-9 The Square, Stockley Park, Uxbridge, Middlesex, UB11 1FW** [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East London
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 14th April 2022 I commenced an investigation into the death of Mrs Thelma Houghton age 79. I opened an Inquest on the 11th July 2022. The Inquest was heard on the 11th April 2023. The conclusion of the inquest was a short-form conclusion, natural causes. The medical cause of death was found to be; 1.a. Small Bowel Ischaemia 2. Right Nephrectomy, Diabetes Mellitus, Left Ventricular Hypertrophy
4	**CIRCUMSTANCES OF THE DEATH** Mrs Houghton had undergone a nephrectomy on 5th April 2022 and had been discharged from hospital. Mrs Houghton's family had sought medical assistance for her through the NHS 111 service at 17.13 hrs on 12th April 2022, reporting that she had been experiencing nausea, bouts of vomiting and was now unrousable. The call resulted in a paramedic visit to Mrs Houghton in the early evening. Paramedics noted that she was hypoglycaemic and provided with I/V Glucose solution. The paramedics were supported by the on-call clinical assessment service, a GP. Against medical advice, Mrs Houghton declined to be taken to hospital. A decision was made for family to monitor Mrs Houghton at home, and for a referral to be made to her GP for follow up the next morning. The GP referral was not affected. On the morning on 13th April 2022 a further call was made by family to 111, further input was given from the on call clinical assessment unit. Advice was given for the family to monitor the patient. Critically, the doctor providing advice did not have full knowledge of what advice had been given by their predecessor or that a GP referral had not been successful. On the evening of 13th April a further call was placed to 111 indicating that Mrs Houghton had deteriorated, again the patient was allocated a call back from the clinical assessment unit within 1 hr. Due to high levels of demand that requirement was not met. At 01.35 on 14th April a courtesy call was made to Mrs Houghton's family who, when it was suggested, agreed to resolve the matter in the morning, after the patient had had some sleep. Early on the morning of 13th April 2022, Mrs Houghton was found unresponsive, paramedics verified her death at 05.44 hrs
5	**<u>CORONER'S CONCERNS</u>** 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. Delay in the provision of emergency response by the 111 service due to a chronic insufficiency of resource.

	2. The absence of a facility in the III computer system to allow advisers from different organisations to review notes made by predecessors. 3. The inadequate pathway of communication between the 111 service and the patient's GP a. A 111 clinical adviser did not have a functioning smart card that would allow both; review of the patient's GP records and the ability to book specifically reserved GP appointment slots. b. The only route for communication between 111 and the GP were letters sent electronically. c. The letters were not streamed for urgency by the GP surgery - meaning that the GP could not discriminate those letters that provided a specific instruction for action and those that did not require action. In this case there was a seven-day delay between the letter arriving at the surgery and it being considered by a GP.
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 **10th July 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, the family of Mrs Houghton and the local Director of Public Health 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 other 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.
9	**[DATE] 16th May 2023 [SIGNED BY CORONER]** [redacted]