Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:
Chief Executive
St Helens and Knowsley Hospitals NHS Trust
Whiston Hospital
Warrington Road
Prescott
L35 5DR

1 CORONER

I am Andre REBELLO, Senior Coroner for the area of Liverpool and Wirral

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 25/11/2020 I commenced an investigation into the death of Helen Margaret Mclean aged 90. The investigation concluded at the end of the inquest on 03 March 2021. The conclusion of the inquest was an Accidental death with the cause of death being:

I a Stroke (Ischaemic)

4 CIRCUMSTANCES OF THE DEATH

On the 11th August 2020 Helen Margaret McLean was admitted to Whiston Hospital. During the admission her warfarin medication was changed to 60mg Edoxaban. Following discharge on 24th September 2020 no discharge summary was received by her GP. She changed from Pilch Lane GP Practice to Aintree Park Group Practice on 28th September 2020.

Aintree Park Group Practice eventually received a copy of the discharge letter from Whiston Hospital on the 8th October 2020, having chased the same. On the 26th October 2020 Mrs McLean transferred home to Christopher Grange Nursing Home. She also transferred back to Pilch Lane GP Practice. There is a no record of Pilch Lane Practice ever receiving the discharge letter from Whiston on interrogation of digital systems. On the 28th October 2020 Christopher Grange reordered all medication, including Edoxaban from Mrs McLean's prescription which came with her when she was admitted. Pilch Lane prescribed all medication apart from Edoxaban. It remains unclear how or why this was done.

Christopher Grange did not cross-reference medication prescribed with medication requested. Christopher Grange stopped the previous medication administration chart and used a new chart which came with the new dispensed prescription. 8 Edoxaban tablets remaining were discarded and Mrs McLean was without medication to prevent blood clots causing circulatory problems from the 5th November 2020. On the 18th November 2020 Mrs McLean was admitted to hospital after an ischaemic stroke. She died on the 21st November 2020. It is found more likely than not that Edoxaban may have prevented this fatal event.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

Following admission to Whiston Hospital on 12th August 2020 the patient was discharged home and a discharge summary was issued. Her GP Practice did not receive this. It is unclear as to why the original summary including medications was not received. However, though summary names a GP but failed to include the GP Practice name and the GP practice identifier was wrong. (copy included only for the recipient's reference). Given the patient's NHS number was accurately stated, please explain this error and rectify your system to prevent repetition.

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 28 April 2021. 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 all Interested Persons

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.

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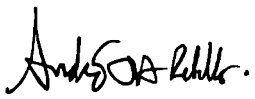

Andre REBELLO
Senior Coroner for
Liverpool and Wirral
Dated: 03 March 2021