Mr. RT
An Interesting Scenario & Attractive Complaint !!

Mr. A Morgan

Consultant Surgeon

3 Stages

A. Hospital Admission
B. Post Discharge
C. Complaint Stage

A. Hospital Admission

- Age : 91
- Admitted to the Ipswich hospital under my care on **13th of March** due to a fall and suspected head trauma,
- Numerous previous falls (More than 10 times recently),
- Residential Home

- **Underlying co morbidities :**
  - Parkinsons,
  - Dementia,
  - HTN,
  - T2DM
  - PPM

- **Lacked the capacity:**
  - "Advanced Dementia" as recorded by Dr.Lockington, care of elderly in his clinic letter dated 17/02/2016. A Formal "Mental Capacity Act Record" was completed on admission.

- Management in Hospital:
  - Contacted RH
  - CT
  - Daily Examination & Neurological Observations
  - Contacted Family “Very Busy Business !!”
  - Overall impression: Very Frail, > 50 % Sleeping
  - QoL
  - DNAR (2 previous DNAR forms Oct. 2015 and Feb. 2016 by medical team (A recent One).
  - End of Life Care

- Day 3 Post admission:
  - Social Team Got involved to Facilitate discharge
  - Social Team and Discharge Coordinator : It was carefully recorded the following in patient's file:
    - 17/03/2016: There are **Adult Safeguarding issues** and there are current investigations to find if the patient is subject to **Deprivation of Liberty Safeguards order**.
    - 17/03/2016: **"Please DO NOT discharge until issues resolved"**
    - 22/03/2016: I documented in notes, Patient is awaiting **Fast track Nursing home due to the Adult safeguarding** issues.

- 24/03/2016: Discharge coordinator : **Patient is from a residential home, but due to ADULT PROTECTION ISSUES, The patient is NOW NOT SUITABLE to return, is awaiting fast track Nursing home**

- 24/03/2016: End of life care : **"Issues with son regarding transfer back to residential home, Spoke with social service advised that Residential home is still in adult protection issues so unable to go back there ! , I have asked social worker xx to speak to son.**

- The Patient was discharged at about just before lunch time on **24th of March**.

- **B. Events Further to Hospital discharge:**
  - **30th of March, (7 Days Later) The Coroner's Office first contacted my sec.**
  - **31st of March : Contacted Coroner Office:**
    - Sadly passed away
    - 25th of March just after 24 hours of discharge
    - In the same Residential Home (Of Previous Concern)
    - Ambulance that took Mr. broke down and he stayed on the side of the road for 7 hours before being able to reach home
    - "Why don't you put the cause of death as Froze to death" !! Son
    - Death was certified by a different doctor
    - The coroner's Office did have a copy of Discharge Summary

- **There are obvious numerous concerns:**
  - The lack of Mental Capacity
  - The Frequent falls more than 10 times recently
  - The DoLS and Safeguarding order
  - Same Residential Home of Concern,
  - The ambulance breakdown
  - I have not certified the death myself
  - The patient was alive & relatively stable for 11 days during his hospital stay but died the next day after discharge.

- Death Certificate !!
  - Who Agrees to issue a Certificate ?
  - Who Objects to issue a Certificate ?

Dr. Peter Dean
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For the attention of colleagues in General Practice - Suffolk

Patients subject to Deprivation of Liberty Safeguards orders

Following the case of P v Cheshire West and Chester Council, March 2014 and recent guidance given to Coroners nationally, HM Coroner for Suffolk is now required to carry out an investigation and inquest into the deaths of all patients who have a DoLS (Deprivation of Liberty Safeguards) order in place.

In view of this, if you are asked to attend to verify death and/or prepare a MCCD for a patient who is subject to a DoLS order, please be aware that the death should be referred to the Coroner's service so that the appropriate process can be followed. The care homes have been instructed to call Suffolk Police using 101 to arrange the attendance of a police officer who will oversee formal identification and the transfer of the deceased in the care of the Coroner's service.

The Coroner's service will contact you for patient information in the usual way as part of their investigation process by asking for a timely written report with an overview of the patient's medical history, the circumstances of the death (which need not be lengthy if the death was natural and there were no additional circumstances of concern or note) and also, if you are in a position to give it, the cause of death (thus avoiding the need for a post mortem examination). This report will serve as the documentary medical evidence for the inquest and avoid the attendance of the doctor in person.

Nursing/residential homes will be aware that a DoLS order is in place but, if needed, verification can be made by calling the Suffolk County Council DoLS team on 01473 260656.

If an application has been made for a DoLS order but it has not yet been formally authorised, the above process does not apply.

Suffolk County Council Adult safeguarding team, in conjunction with Suffolk Police and the Coroner's service, are in the process of preparing an information pack for distribution to all stakeholders involved in DoLS cases. A family information leaflet is also being prepared so that families are made aware of the process which will be followed when death occurs.

In the meantime, in the event of any queries relating to this procedure, please call the Coroner's Service Referral Unit on 01473 613888 x 3159 or email coroners.service@suffolk.gcsx.gov.uk

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- **31st of March**: Long discussion with Coroner and a full report
- Case is going for inquest
- **1st of April** , Coroner Call again
- **Family not happy**:
  - Son will call Newspapers
  - He will even call his local MP
  - Called Bereavement Office , "Heartless Bxxx" !!

- Who will change their decision ?

What Actually Happened ?

- **Peter Dean "The Coroner" of Suffolk:**
  - Death Certificate
  - Form A

- **We are currently investigating:**
  - How was he discharged to same RH
  - How can we learn more about Safeguarding

Time line

- Admitted 13/03/2016
- Discharged 24/03/2016
- Died 25/03/2016 (Good Friday)
- Coroner Office Closed (Friday 25th to Tuesday 29th)
- Coroner Called 30/03/2016 Wed.
- Responded 31/03/2016 Thursday
- Recalled 01/04/2016 Friday
- Resolved 01/04/2016 Friday

Any Questions ?!!