REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted]** **Acting Chief Executive** **Leicestershire Partnership Trust**
1	**CORONER** I am Mrs Catherine Mason, Senior Coroner, for the coroner area of Leicester City and South Leicestershire
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 the 3rd September 2012 I commenced an investigation into the death of Labhuben Amarshi Vaghadia, aged 78 years. The investigation concluded at the end of the inquest on the 28th August 2013. The conclusion of the inquest was Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** On the 25th August 2012 Mrs Vaghadia attended the Leicester Royal Infirmary Accident and Emergency department and was diagnosed as having a suspected deep vein thrombosis in her left calf. She was treated with a subcutaneous anti-coagulant injection into her abdomen and discharged home for daily follow up injections. Late that evening and in the early hours of the 26th August 2012 she experienced bleeding from the injection site. The bleeding had stopped by the time the Community Staff Nurse attended but she was made aware of the history of bleeding. The nurse proceeded to give the anti-coagulant injection and telephoned the Out of Hours services to report the abdominal pain that Mrs Vaghadia was experiencing. A doctor attended later that day and Mrs Vaghadia was admitted to the Leicester General Hospital where she died on the 27th August 2012. The cause of death was 1a) haemorrhage and haematoma of the abdominal wall (injection of Fragmin administered on the 25th August 2012). It is understood that the injection on the 25th may have punctured a blood vessel or gone into the muscle. Both would cause bleeding and are recognised risks. However, due to Mrs Vaghadia's frailty the problem did not resolve naturally as it normally would.
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 will 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) Community Nurse [redacted] administered the anticoagulant on the 26th August 2012 without seeking medical advice from a Doctor even though she knew Mrs Vaghadia had been bleeding from the site of the previous injection. Although the expert evidence in this case is that the nurse's actions did not cause or contribute to the death in this instance, there is a risk that such action in another case may not have the same

	outcome and could be causative of death. (2) Although the nurse had full knowledge of the bleeding she did not share this with other health care professionals when she spoke to them. If she had there was a real possibility that Mrs Vaghadia would have been admitted sooner. In this instance, the expert opined that on a balance of probabilities had Mrs Vaghadia been admitted sooner the outcome was unlikely to have been different. Nevertheless, full and appropriate information sharing is paramount and the nurse's actions fell short of her professional duties and could have caused an adverse outcome. (3) Nurse [redacted] appeared to have no professional insight into her actions and that they could cause or contribute to death. (4) Although not causing or contributing to Mrs Vaghadia's death, it is clear that Nurse [redacted] actions were not appropriate. I have a concern that Nurse [redacted] lacks training and/or experience as well as insight that her actions and therefore her practice may continue and cause future deaths
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 the 23rd October 2013. 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 I have also sent it to [redacted] and [redacted] who may find it useful or of interest. 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 makerepresentations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**5th September 2013**