REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Dr Andrew Goodall, Chief Executive, Aneurin Bevan Health Board, Headquarters, Block A, Mamhilad House, Mamhilad Park Estate, Pontypool NP4 0YP**
1	**CORONER** I am Wendy Ann James, assistant coroner, for the coroner area of Gwent
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 28-03-13 I commenced an investigation into the death of DESRAE REGINA TUCKER (d.o.b. 18/06/44). The investigation concluded at the end of the inquest on the 04-12-13. The conclusion of the inquest was that Desrae Regina Tucker died as a result of a recognised complication following a necessary surgical procedure, the medical cause of death being:- 1 (a) Pulmonary embolism (b) Deep vein thrombosis 2 Recent Cholecystectomy (operated)
4	**CIRCUMSTANCES OF THE DEATH** On 12-03-13 Mrs. Tucker was admitted as an emergency to the Royal Gwent Hospital with abdominal pain. She subsequently underwent surgery for removal of her gall bladder on 20-03-13. She was discharged home on 24-03-13 and died at home on 26-03-13.
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 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) The lack of recording in the patient's notes as to whether the patient was wearing the anti-embolic stockings prescribed. (2) No consideration given as to whether the patient should be discharged home with anti-embolic stockings.

	(3) No anti-coagulant medication prescribed to the patient upon discharge.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 19-03-14. 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 [redacted] 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.
9	**[DATE]** **[SIGNED BY CORONER]** **23-01-14** W A James.