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:** **1. The Chief Executive, Blackpool Teaching Hospital NHS Foundation Trust**
1	**CORONER** I am Alan Wilson, Senior Coroner, for the area of Blackpool & Fylde
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 24th August 2013 I commenced an investigation into the death of Linda Yvonne Fisher, born 16.04.52. The investigation concluded at the end of the inquest on 1st May 2014. The inquest determined that the medical cause of death was Ia Pulmonary Embolism 1b Deep Vein Thrombosis of Left Leg Veins The conclusion of the Coroner as to death was a Narrative Conclusion, as follows: Linda Yvonne Fisher was admitted to hospital on 8th October 2013 complaining of knee pain. An examination undertaken at approximately 22.34 hours on 12th October 2013 suggested that it would be prudent to start treatment for a suspected deep vein thrombosis and a Doppler scan was requested. Dalteparin medication was increased to 15000 units. The Doppler scan was requested on 14th October 2013, performed on 15th October 203 and it confirmed the presence of a left proximal deep vein thrombosis, and Dalteparin medication was increased to 18000 units. Despite ongoing treatment the deceased was found collapsed at approximately 10.40 hours on 17th October 2013 and died. A subsequent post mortem examination undertaken on 21st October 2013 confirmed she had suffered a pulmonary embolism which proved fatal.
4	**CIRCUMSTANCES OF THE DEATH** See the contents of section 3 above
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. The inquest heard evidence that patients may be admitted to hospital who, once medically assessed, may require medication the dosage of which may be determined by the weight of that patient. On occasion such a patient may not be able to be weighed in order to determine their weight, perhaps for example due to a leg injury that prevents the patient bearing their own weight for long enough to allow medical staff to weigh them. In such circumstances, a Doctor placed reliance upon the Deceased's own verbal assessment of her own weight and used this information to decide upon the medication dosage. Although I was informed that the Trust is aware of this issue and have considered one method of resolving it [which I understand is not to be implemented], I remain concerned that patients may be prescribed medications at a dosage which is inaccurately determined due to the fact that a patient has incorrectly assessed their own weight, and if patients do not receive the correct dosage future deaths may result. 2. The inquest also heard evidence that other members of the Deceased's family had suffered from a similar condition. There were no records to suggest that this relevant information had been obtained by medical staff following her admission, and therefore nor had it been communicated effectively to other staff who may in due course have had involvement in her care. I am concerned that if such information is not obtained appropriately from patients and is not communicated effectively to other hospital staff then decisions pertaining to clinical care may be made erroneously and future deaths may result.
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 . 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 Linda Yvonne Fisher The Coroners Society 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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	Alan Wilson **Senior Coroner for Blackpool & Fylde** **Dated: 9th May 2014**