ANNEX A

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:** [redacted] Medical Director Harrogate District Hospital Lancaster Park Road Harrogate North Yorkshire HG2 7SX
1	**CORONER** I am David Hinchliff, Senior Coroner, for the coroner area of West Yorkshire (Eastern) Area
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 26th November 2013, I commenced an Investigation into the death of Carol Lynne Walker, aged sixty-eight years. The Investigation concluded at the end of the Inquest on 18th July 2014. The conclusion of the Inquest was Carol Lynne Walker had suffered a fall causing a hairline fracture of her left ankle and for a plastercast to be applied. Mrs Walker's death was confirmed at her home address, 3 Avon Court, Leeds at 0958 hours on 19th November 2013 as a consequence of her developing a pulmonary thromboembolism because of deep vein thrombosis of the left leg which was a complication of her left ankle fracture. A short form conclusion of accidental death was recorded.
4	**CIRCUMSTANCES OF THE DEATH** 1. Carol Lynne Walker fractured her ankle on 25th September 2013. Mrs Walker was taken by a relative to Harrogate District Hospital on Friday, 25th October 2013 where an x-ray examination revealed that she had suffered a hairline fracture to her left ankle. 2. This was treated by a back slab plastercast. Mrs Walker was discharged after fracture clinic follow-up had been arranged. 3. Mrs Walker was mobilising quite well on hand crutches and was receiving daily help and support from her family. 4. It transpired that from Mrs Walker's previous medical history that she had suffered a pulmonary embolism. It is not clear whether this was communicated to those treating Mrs Walker at the hospital but there was no record made of

	this. Quite clearly, there was an elevated risk of venous thromboembolism. 5. On Monday, 18th November 2013, Mrs Walker informed her family that she was well and that there was no need to visit. At 0930 hours on Tuesday, 19th November 2013 she was discovered by her daughter-in-law in a collapsed state. Paramedics attended who confirmed her death at 0958 hours on 19th November 2013. 6. A Coroner's Post Mortem examination reveals the cause of death to be 1(a) Pulmonary thromboembolism due to (b) deep vein thrombosis of left leg due to (c) left ankle fracture.
	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. I understand that at the time it was not standard practice in either the Orthopaedic Department or the Emergency Department at Harrogate District Hospital to routinely administer Chemical Thrombo Prophylaxis to patients with conservatively treated lower limb injuries immobilising cast considered to be at low risk of venous thromboembolism. 2. Nor was it standard practice in the Trust for a formal venous thromboembolism risk assessment to be undertaken in this patient group.
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. It is my concern that by the very nature of Mrs Whitworth's injury and the fact that her mobility would have been reduced she would have been at risk of venous thromboembolism. In her case the risk would have been heightened by the previous history of pulmonary embolism. I consider that it should be standard practice, both in the orthopaedic and the emergency departments for patients to be risk assessed in respect of the administration of Chemical Thrombo Prophylaxis to patients with lower limb injuries who are immobilised in a cast, who may be considered at low risk of venous thromboembolism.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th September 2014. 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] Medical Director, Harrogate District Hospital. 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]** 4th August 2014 **[SIGNED BY CORONER]**