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:** **1. Chief Executive, Worcestershire Acute Hospitals NHS Trust** **2.** **3.**
1	**CORONER** I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire
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 14th August 2014 I commenced an investigation into the death of Francoise Simone Annabel SNAPE then aged 59. The investigation concluded at the end of the inquest on 11th February 2015. The conclusion of the inquest was she died as the result of a known complication of necessary medical treatment the medical cause of death being Ia) left intracerebral haemorrhage Ib) massive pulmonary embolus (thrombolysed) Ic) left middle cerebral artery territory infarction .
4	**CIRCUMSTANCES OF THE DEATH** On the 2nd August 2014 Mrs Snape was admitted into Worcestershire Royal Hospital following an infarcted stroke. She was managed conservatively until 11th August when she developed a massive pulmonary embolus. Thromboembolitic medication was given which caused a catastrophic bleed resulting in her death.
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) No VTE assessment was ever made of Mrs Snape. The explanation given by [redacted] was that staff were too busy to complete the form and that because she had had a stroke heparin could not be given and therefore the paperwork was unnecessary. (2) NICE guidelines regarding the use of mechanical anti DVT devices instead of heparin in high risk cases was not considered. [redacted] indicated in his

	evidence that the guidance on such matters was to be found in "general" guidance regarding DVTs and not in "stroke" guidance. The clear difference was that he was not aware of the content of the general guidance despite it being specifically referred to as involving stroke patients. It was clear in the Inquest that the absence of a formally completed VTE assessment and lack of knowledge of NICE guidelines amounted to a lost opportunity to make informed decisions for the care of Mrs Snape which may (but only may) have changed the outcome for her. (3)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action i.e. a) to ensure that a full proper and formal VTE assessment is made in all appropriate cases and that paperwork is always fully and properly completed. b) to ensure that all staff (and particularly clinical leads) are aware of all relevant guidelines issued by NICE or other agencies no matter which document it is contained within.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th April 2015 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 Interested Persons [redacted] and [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	**Signed** [redacted] **G U Williams** **H M Senior Coroner** **13th day of February 2013**