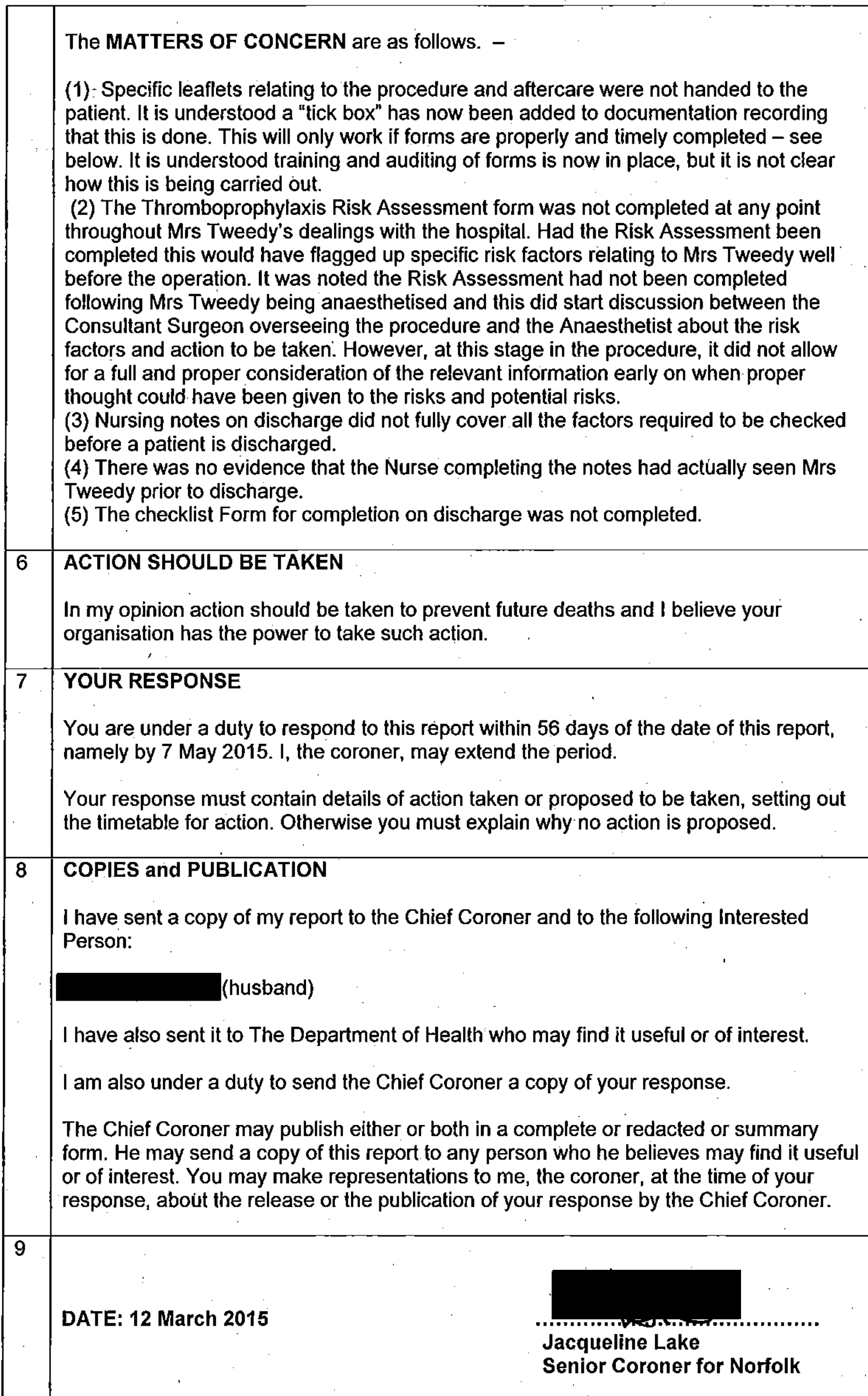
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive** **Norfolk and Norwich University Hospital NHS Foundation Trust** **Trust Headquarters** **Hellesdon Hospital** **Drayton High Road** **Norwich** **NR6 5BE**
1	**CORONER** I am JACQUELINE LAKE, Senior Coroner, for the coroner area of NORFOLK
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 31 March 2014 I commenced an investigation into the death of NICOLA ANNE TWEEDY, AGE, 54 YEARS. The investigation concluded at the end of the inquest on 3 MARCH 2015. The conclusion of the inquest was medical cause of death: 1a) Pulmonary Embolism b) recent varicose vein surgery and narrative conclusion: Mrs Tweedy died following a rare but recognised risk of appropriate surgery.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Tweedy was admitted to NNUH for elective varicose vein surgery as a Day Case patient on 27 March 2014, having seen the Consultant Surgeon on 26 November 2013 and had a pre-operation assessment on 18 March 2014. There was no evidence that Mrs Tweedy had been handed leaflets regarding the procedure and its risks. The Risk Assessment form for Thromboprophylaxis was not completed as indicated at this time. Despite this being noted immediately prior to the procedure, the Risk Assessment form was never completed. Mrs Tweedy was administered a single dose of prophylaxis. Following review of data and procedures, NNUH have noted that varicose vein surgery does show an increased risk of DVT relative to other Day Case procedures. It has now been decided to routinely prescribe 5 days of thromboprophylaxis to all patients undergoing varicose vein surgery unless there are contra-indications. Following the procedure Mrs Tweedy was taken to the Recovery Ward where she was deemed appropriate for Nurse led discharge. Notes were made by a Nurse recording she had passed urine and eaten supper. Before discharge, a Patient is required to be shown to have eaten and had a drink, passed urine, is able to get up and walk, not feel nauseous, had adequate pain relief and understood instructions for care following discharge. A checklist form for completion on discharge had not been completed. ████ raised concerns that his wife was not fit for discharge with a Nurse (it may well have been to a different Nurse) in that she had only walked 10 – 15 paces and left in a wheelchair. On 29 March 2014, Mrs Tweedy was found collapsed and died at her home.
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) Specific leaflets relating to the procedure and aftercare were not handed to the patient. It is understood a "tick box" has now been added to documentation recording that this is done. This will only work if forms are properly and timely completed – see below. It is understood training and auditing of forms is now in place, but it is not clear how this is being carried out.

(2) The Thromboprophylaxis Risk Assessment form was not completed at any point throughout Mrs Tweedy's dealings with the hospital. Had the Risk Assessment been completed this would have flagged up specific risk factors relating to Mrs Tweedy well before the operation. It was noted the Risk Assessment had not been completed following Mrs Tweedy being anaesthetised and this did start discussion between the Consultant Surgeon overseeing the procedure and the Anaesthetist about the risk factors and action to be taken. However, at this stage in the procedure, it did not allow for a full and proper consideration of the relevant information early on when proper thought could have been given to the risks and potential risks.

(3) Nursing notes on discharge did not fully cover all the factors required to be checked before a patient is discharged.

(4) There was no evidence that the Nurse completing the notes had actually seen Mrs Tweedy prior to discharge.

(5) The checklist Form for completion on discharge was not completed.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 7 May 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 following Interested Person:

(husband)

I have also sent it to The Department of Health 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 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: 12 March 2015

....

Jacqueline Lake
Senior Coroner for Norfolk