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Thomas R Osborne
Senior Coroner for Bedfordshire and Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **Mr N Carver** **Chief Executive** **East & North Hertfordshire NHS Trust** **Coreys Mill Lane** **Stevenage** **Herts. SG1 4AB**
1	**CORONER** I am **Thomas R Osborne**, Senior Coroner for Bedfordshire and Luton
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 16th September 2014 I commenced an Investigation into the death of **LORRAINE JOYCE BIRD** aged 67 years. The Investigation concluded at the end of the inquest on 05th August 2015. The Conclusion of the Inquest was a Narrative Conclusion "...Lorraine Joyce **BIRD** fell over and fractured her ankle on 19th August 2014. She was treated at Colchester General Hospital on 20th August 2014 and the ankle was put in plaster. She was not treated with low molecular weight Heparin but elected to take Aspirin instead. She attended the Plaster Room at the Queen Elizabeth Hospital in Welwyn Garden City on 10th September 2014 complaining of numbness. There was a failure to recognise the development of a Deep Vein Thrombosis on 10th September, 2014, which resulted in a lost opportunity to render further medical treatment and she died on 13th September 2014.
4	**CIRCUMSTANCES OF THE DEATH**

	On the 19th of August 2014 Lorraine suffered a fall at Colchester Zoo which resulted in a fractured right ankle. It is understood that a plaster cast was fitted but this was then re-fitted as she complained of it being too tight and was seen at the Lister Hospital in relation to this. An Ultrasound was carried out on 26th August 2014, which was normal. On the 12th September 2014 Lorraine went to bed as usual, but at 01.15 hours her husband was awoken by her gasping for breath. Paramedics were called and cardiopulmonary resuscitation was commenced but sadly her death was pronounced shortly after their arrival.
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) That on the 10th September 2014 Mrs. Bird attended the Plaster Room at the Queen Elizabeth Hospital complaining of numbness in her foot and possible swelling; this was at least three weeks following the original injury. She was probably developing a deep vein thrombosis (DVT) and yet she was sent home after treatment by the Plaster Technician without a medical review. (2) There appears to be a complete lack of a Protocol for the assessment of patients who attend for treatment at the Plaster Room. (3) The evidence before me was that if the DVT had been detected, and the appropriate treatment had been administered on that date, it is unlikely that she would have suffered a fatal pulmonary embolism on the 13th September 2014.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as Chief Executive 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 **5th October 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 Persons : **The Chief Executive - Colchester General Hospital** **Chief Executive – NHS England** **The family** 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	**Dated 10th August 2015** [redacted] ..... **THOMAS R. OSBORNE** **Senior Coroner** **for Bedfordshire and Luton**

Thomas R Osborne
Senior Coroner for Bedfordshire and Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **Mr Simon Stevens** **Chief Executive** **NHS England** **PO Box 16738** **Redditch. B97 9BT**
1	**CORONER** I am **Thomas R Osborne**, Senior Coroner for Bedfordshire and Luton
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 16th September 2014 I commenced an Investigation into the death of **LORRAINE JOYCE BIRD** aged 67 years. The Investigation concluded at the end of the inquest on 05th August 2015. The Conclusion of the Inquest was a Narrative Conclusion "...Lorraine Joyce **BIRD** fell over and fractured her ankle on 19th August 2014. She was treated at Colchester General Hospital on 20th August 2014 and the ankle was put in plaster. She was not treated with low molecular weight Heparin but elected to take Aspirin instead. She attended the Plaster Room at the Queen Elizabeth Hospital in Welwyn Garden City on 10th September 2014 complaining of numbness. There was a failure to recognise the development of a Deep Vein Thrombosis on 10th September, 2014, which resulted in a lost opportunity to render further medical treatment and she died on 13th September 2014".
4	**CIRCUMSTANCES OF THE DEATH** On the 19th of August 2014 Lorraine suffered a fall at Colchester Zoo which

	resulted in a fractured right ankle. It is understood that a plaster cast was fitted but this was then re-fitted as she complained of it being too tight and was seen at the Lister Hospital in relation to this. An Ultrasound was carried out on 26th August 2014, which was normal. On the 12th September 2014 Lorraine went to bed as usual, but at 01.15 hours her husband was awoken by her gasping for breath. Paramedics were called and cardiopulmonary resuscitation was commenced but sadly her death was pronounced shortly after their arrival.
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) In September 2013 The College of Emergency Medicine issued a "Guideline for the use of Thromboprophylaxis in Ambulatory Patients Requiring Temporary Limb Immobilisation". This recommends the use of Low Molecular Weight Heparin (LMWH) to be used until the plaster is removed. (2) When Lorraine Bird attended Colchester Hospital she was not given LMWH. The hospital had not yet introduced the Guideline, although they were in the process of trying to agree the funding to enable them to adopt it. (3) I believe consideration should be given as to whether the Guideline should be adopted by all Hospitals to avoid the development of DVTs by similar patients in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as Chief Executive of NHS England 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 the **5th October 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 Persons: **Chief Executive - Colchester Hospital** **Chief Executive - East & North Herts NHS Trust** **The family** 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	**Dated 10th August 2015** [redacted] ..... **THOMAS R. OSBORNE** **Senior Coroner** **for Bedfordshire and Luton**

H.M. CORONER BEDFORDSHIRE AND LUTON

Senior Coroner, The Court House, Woburn Street, AMPTHILL, Bedfordshire, MK45 2HX
Tel 0300-300-6559 | Fax 0300-300-8267