REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. Karen Baker, Chief Executive of the Isle of Wight NHS Trust**
1	**CORONER** I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight.
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 23rd January 2015 I commenced an investigation into the death of Ann Hardman, aged 73. The investigation concluded at the end of the inquest on 6th October 2016. The conclusion of the inquest was Natural Causes. The medical cause of death was found to be: 1a Pulmonary Thromboembolism 1b Thrombosis of the Deep Veins of the Left Calf 1c 2
4	**CIRCUMSTANCES OF THE DEATH** 1) Ann Hardman presented at her GP's practice on 13th January 2015 complaining of a three-week history of a painful left calf and cough. She was examined and found to have a swollen left calf, but her chest examination was normal. She was apyrexial and had oxygen saturation of 97% and a regular pulse of 70bpm. A D-Dimer test was undertaken which gave a positive result. Her Wells Score was 2 due to her left calf being swollen by more than 3cm than her right leg, and because there was pitting oedema on her left leg. Her GP gave her an injection of Clexane and sent her directly to St Mary's Hospital for an ultrasound scan of her left leg to rule out a deep vein thrombosis. 2) Later that day at St Mary's Hospital, she was scanned by an ultrasound sonographer who had difficulty carrying out the scan effectively as Mrs Hardman

was a morbidly obese lady, resulting in a poor quality scan of her leg. The ultrasound sonographer reported back to her GP as follows: "Suboptimal scan due to technical limitations associated with the patient's build. The common femoral vein, superficial femoral vein, popliteal vein and deep calf veins were assessed and no evidence was seen of an acute DVT on today's scan." Evidence heard at the Inquest from the sonographer revealed that the language that she had used was ambiguous inasmuch as the "technical limitations" referred to the difficulty carrying out an effective scan due to Mrs Hardman's obesity, and that "no evidence was seen of an acute DVT" meant that a DVT couldn't be seen, but due to Mrs Hardman's obesity, it was impossible to be certain that there definitely was no DVT in her left leg.

3) Mrs Hardman had no further dealings with her GP's practice before 20th January 2015.

4) On 20th January 2015, Mrs Hardman contacted her GP's practice complaining of chest pain and requesting an appointment. The receptionist told her to dial 999 or offered to do it for her. Mrs Hardman declined this advice and shortly thereafter she was found dead at home by her daughter.

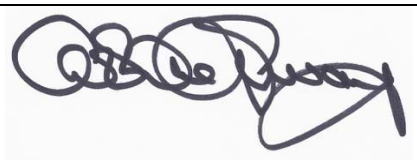
5) Evidence heard at the Inquest revealed that various protocols had changed since Mrs Hardman's death, including that it is now the practice after a negative ultrasound scan for a DVT to rescan the patient 6-8 days later, and that this new practice had found 5 previously undiagnosed DVTs in patients who had previously been given a negative ultrasound scan thereby saving 5 lives, however this relies on the patient revisiting their GP and being given another referral form for a scan at St Mary's Hospital.

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 am concerned that when there is a negative scan for a DVT at St Mary's Hospital, the current protocol relies on the patient returning to their GP and being given another referral form for a further scan 6-8 days later. It was accepted that a better system would be one whereby the patient was automatically told to return for a further scan a week or so later by the ultrasound department, subject to the patient's GP cancelling this scan, based

	on their clinical judgement of any review of the initial scan and/or any further examination of the patient. This would remove the chance of patients failing to be told to re-attend for a further scan.
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 21st November 2016. 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 Ann Hardman. 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	 **H.M. Senior Coroner – Isle of Wight** **10th October 2016**