REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Dudley group of Hospitals NHS Trust.** **2. Chief Coroner**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 16 March 2017, I commenced an investigation into the death of the late Mr Kenneth Evans. The investigation concluded at the end of the inquest on 10 May 2017. The conclusion of the inquest was a narrative conclusion: Mr Evans had a fall at home and he fractured his pubic ramus. He was admitted to Russells Hall hospital on the 27 February 2017 and no risk assessment for developing clots was undertaken. He subsequently developed a pulmonary embolus and died on the 11 March 2017. There was a failure to risk assess him for clots and also missed opportunities to administer heparin to minimise the risk of developing a pulmonary embolus and these were gross failures in basic medical care giving rise to neglect. The cause of death was: 1a Pulmonary Embolus b Immobility c Mechanical Fall
4	**CIRCUMSTANCES OF THE DEATH** i) Mr Evans had a mechanical fall on 26 February 2017 when he tripped and twisted his left hip. He was unable to weight bear and admitted to Russell's Hall Hospital on February 27. A probable fractured pubic ramus was diagnosed and he was treated conservatively with no surgery being indicated. ii) He was then transferred to the Evergreen ward which is a GP-lead ward of the hospital. iii) At 08:00 on 10th March he became suddenly short of breath with chest pain and the Medical Emergency Team (MET) was called. An urgent CT scan of the chest at 12:26 showed an extensive 'saddle' pulmonary embolism. iv) He was given therapeutic Dalteparin for treatment of the clot and he was admitted to the Medical High Dependency Unit. An echocardiogram demonstrated severe Right Ventricular impairment and dilatation with

	secondary Left Ventricular impairment. This is an indication for thrombolysis so he was given Alteplase at 17:00 and started on an IV Heparin infusion. v) A further MET call was put out at 17:45 as he had become peri-arrest (low oxygen levels and hypotension). He subsequently arrested (PEA rhythm) requiring Advanced Life Support. The total time without a cardiac output was around 20 minutes before return of spontaneous circulation. He was then admitted to the Intensive Care Unit for on-going management. vi) The next morning he needed increasing amounts of adrenaline and became unstable. The family had been fully informed of diagnosis, management and his poor prognosis. After continued period of hypotension the decision was taken to stop active treatments and focus on the patient's comfort and dignity. Sadly, he passed away on the 11 March 2017.
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. Evidence emerged during the inquest that thromboprophylaxis was not arranged and no effective risk assessment of developing blood clots was undertaken.
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. 1. You may wish to consider setting up a review of the policy and training for the relevant staff the requirements for thromboprophylaxis for patients who are immobile due to a history of falls.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 July 2017. 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; Family. 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	**30 May 2017** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**