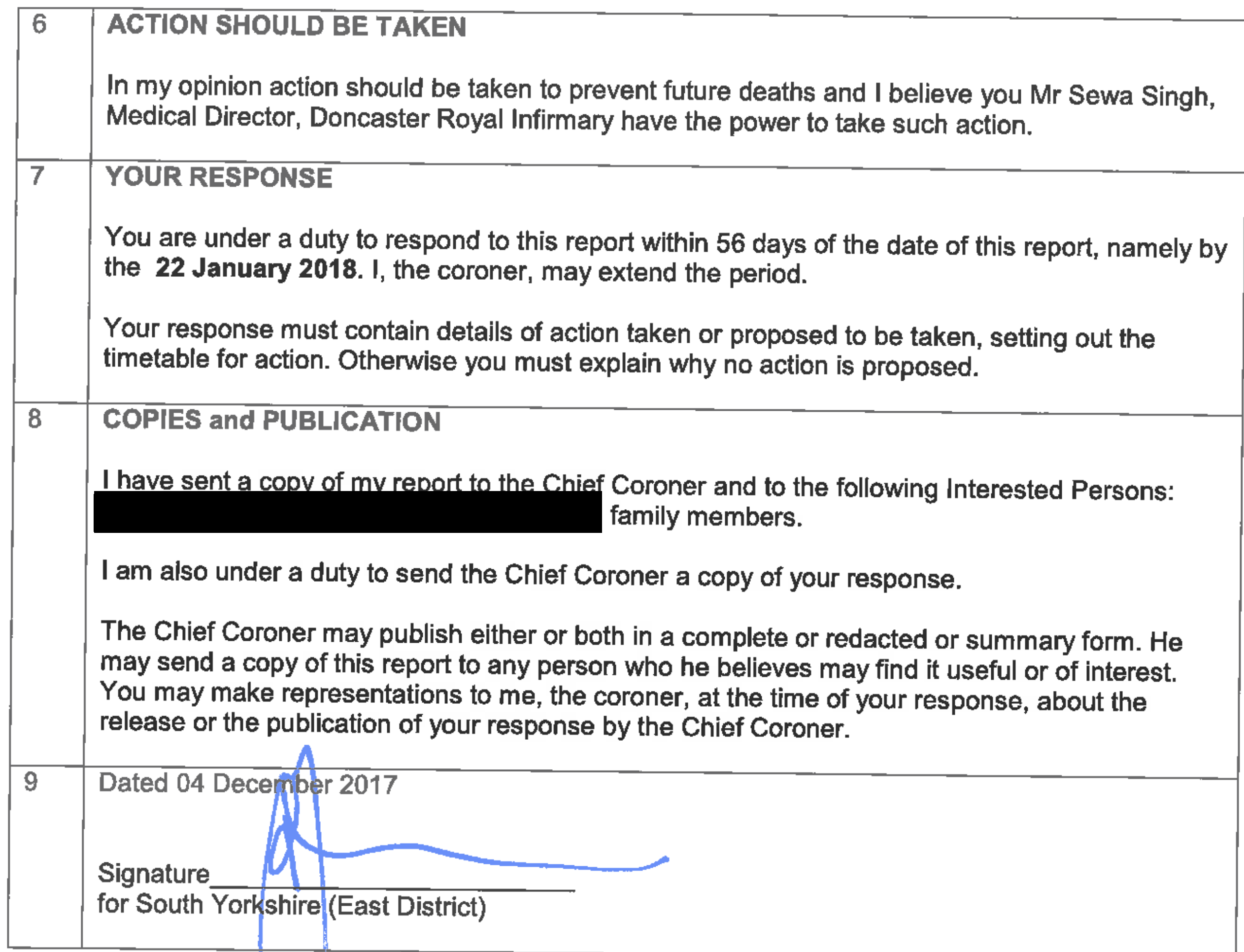
for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Sewa Singh, Medical Director, Doncaster Royal Infirmary**
1	**CORONER** I am Ms NJ Mundy, Senior Coroner for South Yorkshire (East District)
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 24/04/2017 I commenced an investigation into the death of Gordon Frank Thornhill, 61 years. The investigation concluded at the end of the inquest on 27 November 2017. The conclusion of the inquest was natural causes. Gordon Frank Thornhill died on 13 April 2017 when a period of significantly reduced incapacity led to DVT development and death from pulmonary embolism.
4	**CIRCUMSTANCES OF THE DEATH** A 61 year old man who developed abdominal pain at times radiating to his shoulder and lower back. He had attended at DRI A & E on 4th April 2017 and was discharged on 6th April. He attended A & E again on 8th April 2017 was seen and discharged. He then collapsed and died at home on 13th April 2017. I heard evidence from Mr Hossenbux, Consultant in Emergency Medicine that the VTE risk assessment had not been completed. On subsequently reviewing notes it appeared it had been partially completed. In any event, I was told that this is a mandatory assessment which must be undertaken for all admitted patients. The partially completed VTE risk assessment had the box ticked as Mr Thornhill been at high risk for VTE and was for thromboprophylaxis but despite this it was over 24 hours before that prophylaxis was administered.
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) Junior doctor's failure to fully complete the mandatory VTE risk assessment. (2) The Consultant's VTE assessment done the day following admission failed to identify incomplete/failure to complete VTE risk assessment. (3) The Consultant carried out his own assessment as a "mental exercise" and did not document his assessment. (4) A delay in excess of 24 hours in providing thromboprophylaxis.



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Mr Sewa Singh, Medical Director, Doncaster Royal Infirmary 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 **22 January 2018**. 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 members. 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 04 December 2017 Signature________________________ for South Yorkshire (East District)

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