Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Telephone 0208 447 7680
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Ministerial Correspondence and Public Enquiries Unit Department of Health and Social Care 39 Victoria Street London SW1H 0EU United Kingdom 2.Legal Department North Middlesex University Hospital, Sterling Way, London N18 1QX
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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 15th May 2019 I opened an investigation touching the death of Joseph Arthur Charles , aged 82 years old. I opened and inquest on the 24th may 2019. The inquest concluded on the 6th August 2019. The conclusion of the inquest was " Consequences of surgery following a fall at home", the medical case of death was 1a Pulmonary thrombo-embolism, 1b Deep vein thrombosis 1c Recent surgery (right elbow) and under paragraph 2 Ischaemic heart disease, type 2 diabetes mellitus, vhronic obstructive pulmonary disease.
4	**CIRCUMSTANCES OF THE DEATH** On the Eighteenth of April 2019 Joseph Arthur Charles fell at his home and was taken to hospital where he had surgery to his right elbow on the Third of May 2019. Mr Charles was discharged home on the Eleventh of May 2019 and was found unresponsive in his bed by his wife on the Fourteenth of May 2019. Had Mr Charles had surgery to his lower limb he would have fallen within the National guidelines for the prevention of DVT and pulmonary embolus but there are no such recommendations for upper limb surgery.

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5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – That although there are clear National guidelines for the prevention of DVT and pulmonary embolus but there are no such recommendations or guidance for upper limb surgery.
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 Tuesday 1st October 2019, 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;- Trust Department of Health 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	**6th August 2019**