IN THE SURREY CORONER'S COURT

IN THE MATTER OF: Peter James Michael Unsworth

The Inquest Touching the Death of PETER JAMES MICHAEL UNSWORTH

A Regulation 28 Report – Action to Prevent Future Deaths

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] **Chair of NHS Improvement** • [redacted]**, Chair of the Royal College of Physicians** • [redacted]**, President of the Royal College of Surgeons** • [redacted]**, Chair of the General Medical Council** • [redacted]**, Chief Executive of St Peter's Hospital, Chertsey**
1	**CORONER** I am Caroline Topping HM Assistant Coroner, for the coroner area of Surrey
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** An inquest into the death of Peter James Michael Unsworth was opened on the 9th August 2018 and resumed on the 21st October 2020. The inquest concluded on 2nd November 2020. I concluded that the medical cause of his death was; 1a Pulmonary Thrombo-Embolism

	1b Deep Vein Thrombosis I concluded with a narrative conclusion: Peter James Michael Unsworth had developed deep vein thromboses twice and was on long term anticoagulant medication prior to having a right hip replacement operation in April 2018. On the 23rd May 2018 he was admitted to hospital as an emergency. He was found to have developed a further deep vein thrombosis and his right hip was severely infected. Administration of anticoagulation medication was a significant factor in the development of the infection. He required a lifesaving operation to washout the infected hip prior to which an IVC filter was implanted to prevent pulmonary emboli. Thereafter he underwent the first stage of revision surgery. He remained treated on a therapeutic dose of Clexane post operatively. Haematological advice was sought as to whether the dose of Clexane could be reduced to prevent a further infection developing in the right hip. No note was made of the advice given. The orthopaedic surgeon with responsibility for his care understood that he could reduce the Clexane dose to a prophylactic dose if, in his clinical judgment, this was necessary to prevent a further hip infection. He reduced the dose of Clexane to a prophylactic dose. As a consequence of reduced anticoagulation Peter Unsworth developed pulmonary emboli which totally occluded his pulmonary arteries. He died at home at [redacted], Shepperton on the 29th July 2018.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are detailed in the narrative conclusion.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – The evidence showed that: 1. The advice provided by the Consultant Haematologist related to a very complex medical situation. It was not recorded in writing. The Consultant Orthopaedic surgeon did not record it in the patient's records nor email his understanding of the advice to the Consultant Haematologist for confirmation of what he understood the advice to be. 2. The Consultant Haematologist did not confirm her advice in writing or make any record of the advice given. 3. As a consequence, there may have been a misunderstanding of the basis on which the advice was sought and/or given, and of the import of the advice.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 25th January 2021. 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; [redacted] [redacted] I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your report to any other person who I believe may find it useful or of interest. 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	**Signed:** **Caroline Topping** **Dated this 1st December 2020.**