MR G IRVINE
ACTING SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] CEO, BHRUT NHS Trust, Queens Hospital, Rom Valley Way, Romford, RM7 0AG [redacted] 2. Department of Health & Social Care [redacted]
1	**CORONER** I am Graeme Irvine, acting senior coroner, for the coroner area of East 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. 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 27th July 2020 I commenced an investigation into the death of Mrs Vivien Brunning, aged 87 years. The investigation concluded at the end of the inquest on 7th October 2021. The conclusion of the inquest was that Mrs Brunning died from; 1a Right Basal Ganglia and Occipital Lobe Ischaemic Strokes 1b Atheromatous thromboembolism during attempted thrombolysis for right brachial artery thrombosis

	1c Urosepsis and urinary tract obstruction (treated); systemic atheromatosis, hypercoagulability (omission of clexane therapy) II Diabetes Mellitus; atrial fibrillation A short form conclusion of accidental death was arrived at. A narrative conclusion was arrived at.
4	**CIRCUMSTANCES OF THE DEATH** On 9th July 2020 Mrs Vivien Brunning was admitted to hospital with sepsis. Mrs Brunning had been treated in the community with anti-coagulants for atrial fibrillation. In hospital, a venous thromboembolism ("VTE") assessment indicated that Mrs Brunning required prophylaxis to mitigate the risk of developing deep vein thrombosis as an inpatient, she was prescribed low molecular weight heparin ("Clexane"). Mrs Brunning was diagnosed with a kidney stone and underwent a nephrostomy to treat the source of her infection. As a precaution, clexane was held, temporarily, to mitigate the risk of bleeding in the procedure. Following the procedure, clexane was to be resumed and was administered on 12th July 2020. On 13 & 14th July 2020 clexane was not administered to Mrs Brunning, in error. On 15th July 2020 Mrs Brunning was diagnosed with a thrombosis in her right brachial artery, a causal factor in the formation of the clot were the two missed doses of clexane. Mrs Brunning underwent an emergency thrombolysis procedure to dissolve the clot, during the procedure she suffered a stroke due to a recognised complication of the essential, emergency procedure. Mrs Brunning died on 25th July 2020 due to the effects of the stroke.
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 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. – 1. The hospital notes demonstrate that required venous thromboembolism reviews at 24 & 72 hrs following admission were not undertaken. 2. Prescribed daily injections of low molecular weight heparin were omitted on 13th and 14th July 2020 3. The initial omission on 13th July 2020 was noticed by a ward doctor but was not reported through the Trust's incident reporting system.
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 **7th December 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 the family of Mrs Brunning and the CQC. I have also sent it to the local Director for Public Health who may find it useful or of interest. 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 response 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.
9	**[DATE] 12th October 2021 [SIGNED BY CORONER]**