

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none"> 1. General Medical Council 2. N.I.C.E. 3. The Chief Coroner
1	<p>CORONER</p> <p>I am Philip Alan Sharp, Assistant Coroner, for the coroner area of South and East Cumbria</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 16th September 2013 I commenced an investigation into the death of Elizabeth Jayne Cooper who was born on the 2nd Nov 1980. The investigation concluded at the end of the inquest on 23rd April 2014. The conclusion of the inquest was that Elizabeth died of 1a Pulmonary Thromboembolism 1b Deep Vein Thrombosis right lower limb 1c Hypercoagulable state due to Factor V Leiden mutation. I gave a conclusion of natural causes.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Elizabeth had been diagnosed with the genetic condition referred to in 1c above in 2011. This followed a diagnosis of a DVT and possible pulmonary embolism. Elizabeth was clinically obese and suffered from diabetes. She was thereafter given conflicting advice on the precautions she should take if she travelled by air. One specialist advised her to take anticoagulant prophylaxes but her GP did not consider this to be necessary. She died immediately following a holiday to Tenerife involving air travel. No causal connection was made in the inquest between the flights and her death but it became clear from the evidence that although she was aware of the risks created by the condition and other risk factors she seemed not to be aware of the consequences of taking any of those risks of which flying was one. Her actions on becoming ill on holiday support this conclusion. The literature from her specialist did not give any warnings in this regard. The guidelines produced to the inquest highlight the statistical increase of risks but not the consequences of an untreated DVT. Her sister who gave evidence, although not carrying the genetic condition, had previously suffered a DVT and was similarly not aware of the fatal consequences of an untreated DVT. Further her family had not been made aware of the option to be tested for the genetic condition to enable them to properly consider their own health requirements.</p>
5	<p>CORONER'S CONCERNS</p> <p>During the course of the inquest the above 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.</p>

	<p>The MATTERS OF CONCERN are as follows:-</p> <p>(1) Advice on precautions to be taken for those persons with the genetic condition is unclear especially concerning air and long distance travel.</p> <p>(2) There seems no clear pathway for information concerning the condition to be passed to members of the family of the patient for them to assess their own position.</p> <p>(3) No information leaflet</p> <p>(a) was available to Elizabeth concerning the fatal consequences of not seeking medical assistance;</p> <p>(b) was available to be given to members of Elizabeth's family to inform them of the risks involved in Factor V Leiden Mutation and the options open to them.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe your Organisation has the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 26th June 2014. I, the Assistant Coroner, may extend the period.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED] (Sister) [REDACTED] (Elizabeth's GP). I have also sent it to The British Society of Physicians who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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 of the publication of your response by the Chief Coroner.</p>
9	<p>[DATE] [SIGNED BY CORONER]</p>