ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, Portsmouth Hospitals NHS Trust**
1	**CORONER** I am David Clark Horsley, senior coroner, for the coroner area of Portsmouth and South East Hampshire.
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 28th June 2013 I commenced an investigation into the death of Stephen Anthony Mayoll, aged 44. The investigation concluded at the end of the inquest on 19th November 2014. The conclusion of the inquest was: Narrative Conclusion: 1- On 10th June 2013 Stephen Anthony Mayoll fell from a ladder at work and sustained a right Achilles tendon injury for which he received treatment as an out-patient at Queen Alexandra Hospital, Portsmouth, between 11th and 20th June 2013. 2- On 21st June 2013 he became very unwell at home and was taken by ambulance to Queen Alexandra Hospital where he died at 03.20 hours on 22nd June 2013. 3- He died as a result of complications of his injury and its treatment at the hospital between 11th and 20th June 2013, namely a pulmonary thromboembolism arising from a deep vein thrombosis in his right lower leg. Mr Mayoll did not fulfil the criteria then in force at the hospital for the use of anti-coagulation therapy in respect of Achilles tendon injury patients and in consequence did not receive such therapy which, on the balance of probabilities, would have reduced the risk of those complications arising.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Mr Mayoll's death are set out in Paragraph 3 above.
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 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- Out-patients with similar injuries to Mr Mayoll's returning to the fracture clinic at

	Queen Alexandra Hospital experiencing problems with their treatment or for periodic review are not subject to re-assessment under the hospital's DVT assessment policy. If they were, there would be less risk of their developing DVT's during the course of their treatment. 2- Evidence was given at the Inquest highlighting the delay in typing fracture clinic doctors' notes meaning that they would not always be available if an out-patient returned to the clinic and improved methods of making the notes available sooner to the clinic (e.g. by use of voice recognition IT) would obviate this problem.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 20th January 2015. 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: 1- [redacted] 2- RCN Legal Services [redacted] 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	**25th November 2014** **[SIGNED BY CORONER]**