REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Mr C Brown Chief Executive East Kent Hospitals University NHS Trust Kent and Canterbury Hospital Ethelbert Road Canterbury CT2 3NG
1	**CORONER** I am Rachel Redman Senior Coroner, for the Coroner area of Central and South East Kent
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 12 February 2015 I commenced an investigation into the death of Patricia Anne HOLMES. The investigation concluded at the end of the Inquest on 24 June 2015. The conclusion of the inquest was that Accidental.
4	**CIRCUMSTANCES OF THE DEATH** Patricia Anne Holmes presented at William Harvey Hospital on 1 February 2015 where a number of fractured ribs were diagnosed on chest x-ray and information was given to the A&E staff by her family that she was receiving anticoagulation therapy for a pulmonary embolus and that at the last clinic appointment on 30 January her INR was 6. No action was taken to reverse the effect of the anticoagulation therapy. Mrs Holmes presented again to William Harvey Hospital on 2 February in a state of collapse and died two days later. The cause of death is: 1a) Haemothorax 1b) Rib fracture with lung laceration II Hypertensive heart disease, Coronary atheroma.
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: The staff grade A&E doctor who treated Mrs Holmes on 1 February did not consider what action was necessary given the history of trauma and multiple fractured ribs on x-ray and that she was at risk of internal bleeding since she was receiving anticoagulation therapy.

6	**ACTION SHOULD BE TAKEN** A protocol should be drawn up for the A&E Department to provide for the consideration of reversal of anticoagulation therapy in all cases where a patient has sustained trauma and is in receipt of this type of medication.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th August 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 Person(s): [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	Signed: Rachel Redman Senior Coroner [redacted] 2 July 2015