REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive Officer** **East Lancashire Healthcare NHS Trust** **Trust Headquarters** **The Royal Blackburn Hospital** **Haslingden Road** **Blackburn BB2 3HH**
1	**CORONER** I am Michael Singleton, Senior Coroner for the Coroner area of Blackburn, Hyndburn & Ribble Valley.
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 the 17th day of March 2016 I commenced an investigation into the death of Karen Elizabeth Ravenscroft aged 60 years. The investigation concluded at the end of the Inquest which was concluded on the 18th day of May 2016. The conclusion of the Inquest was that Karen Ravenscroft had died an accidental death.
4	**CIRCUMSTANCES OF THE DEATH** On the 11th March 2016 Karen Ravenscroft fell at her home address and fractured both her left arm and left leg. At the Royal Blackburn Hospital she was assessed of high risk of development of deep vein thrombosis. She was not provided with the appropriate prophylaxis and developed a deep vein thrombosis which caused a fatal pulmonary embolus.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving arise to concern. In my opinion there is a risk that further deaths will occur unless action is taken. In the circumstances it is my duty to report to you the **MATTERS OF CONCERN** is as follows: - 1. The initial venous thromboembolism risk assessment done during the admission as per the Trust's VTE Guidelines stated that Mrs Ravenscroft was at high risk for VTE with no bleeding risk and no contra-indication for

	pharmacological thromboprophylaxis. Despite that no thromboprophylaxis was prescribed. 2. Despite Trust VTE Guidelines recommending re-assessment of VTE risk at 24 hours after admission, no further risk assessment took place nor was there application of mechanical thromboprophylaxis like Ted Stocking or Flowtron Pump. 3. Evidence revealed that drugs prescribed in the Accident & Emergency Department could not be done electronically without the doctor going on the ward in order to be able to do that.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 18th July 2016. I, the Coroner, may extend this 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, namely: [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	**23 May 2016** **Signed by:** ..... **H M Senior Coroner for Blackburn, Hyndburn & Ribble Valley**