REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Professor Andrew Hardy, Chief Executive, University Hospitals Coventry & Warwickshire NHS Trust, University Hospital, Clifford Bridge Rd, Walsgrave, Coventry CV2 2DX**
1	**CORONER** I am Emma Whitting, Assistant Coroner for the Coroner area of Coventry
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/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 23 March 2017, I commenced an investigation into the death of Mr Robert Dymond, aged 61. The investigation concluded at the end of the inquest on 20 July 2017. The medical cause of death was found to be: 1a Pulmonary Thromboembolism due to 1b Deep Vein Thrombosis 1c Obesity and Recent Surgery for Knee Replacement The Conclusion of the inquest was a Narrative Conclusion: *Died from a recognised complication of surgery.*
4	**CIRCUMSTANCES OF THE DEATH** On 20 May 2015, Mr Dymond has been placed on the waiting list for elective left knee replacement surgery. As he was considered to be a high risk patient owing to his previous medical history, which included a high BMI of 42.1, he had to undergo this at UHCW which has a Critical Care Unit. He had an initial pre-op assessment on 21 July 2016 and a further pre-op assessment on 12 January 2017. Despite the fact that he had undergone investigation and preliminary treatment for a suspected DVT in November 2016 at UHCW, I was informed that the pre-op assessment in January 2017 had noted no changes since the previous one. The Consultant Orthopaedic Surgeon performing the surgery was not informed of the events in November 2016. The surgery was performed on 9 March 2017. On the morning of 10 March 2017, and despite appropriate post-operative VTE prophylaxis, he suffered a massive thromboembolic event and passed away on 11 March 2017.
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) Following referral to the UHCW DVT Clinic by his GP on 22 November 2016 with a suspected DVT, Mr Dymond, having a Wells score of 2, was assessed as being 'likely' to be suffering from a DVT – the investigations included a D-Dimer blood result of 0.97 – and he was discharged home with instructions to self-administer therapeutic LMWH (Clezane) doses at home twice daily in his stomach pending an ultrasound scan booked for 25 November 2016. The scan performed on 25 November 2016 apparently revealed no evidence of a DVT and he was discharged back to the care of his GP. Although the clinical management appeared to conform with the UHCW protocol in place at the time, this protocol did not appear to conform with NICE Guideline 144 (specifically section 1.1.3) which (since 2012) advises *a repeat proximal leg vein ultrasound scan 6-8 days later for all patients with a positive D-dimer test and a negative proximal leg ultrasound scan);* (2) Neither the Consultant Orthopaedic Surgeon nor the Anaesthetist performing the operation on 9 March 2017 had been made aware of the DVT investigations/treatment in November 2016; (3) The DVT investigations/treatment in November 2016 did not appear to feature in the second pre-operative assessment carried out on 12 January 2017.
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 **19 September 2017**. 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 Mr Dymond's family. 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	**25 July 2017 SIGNED BY ASSISTANT CORONER:**