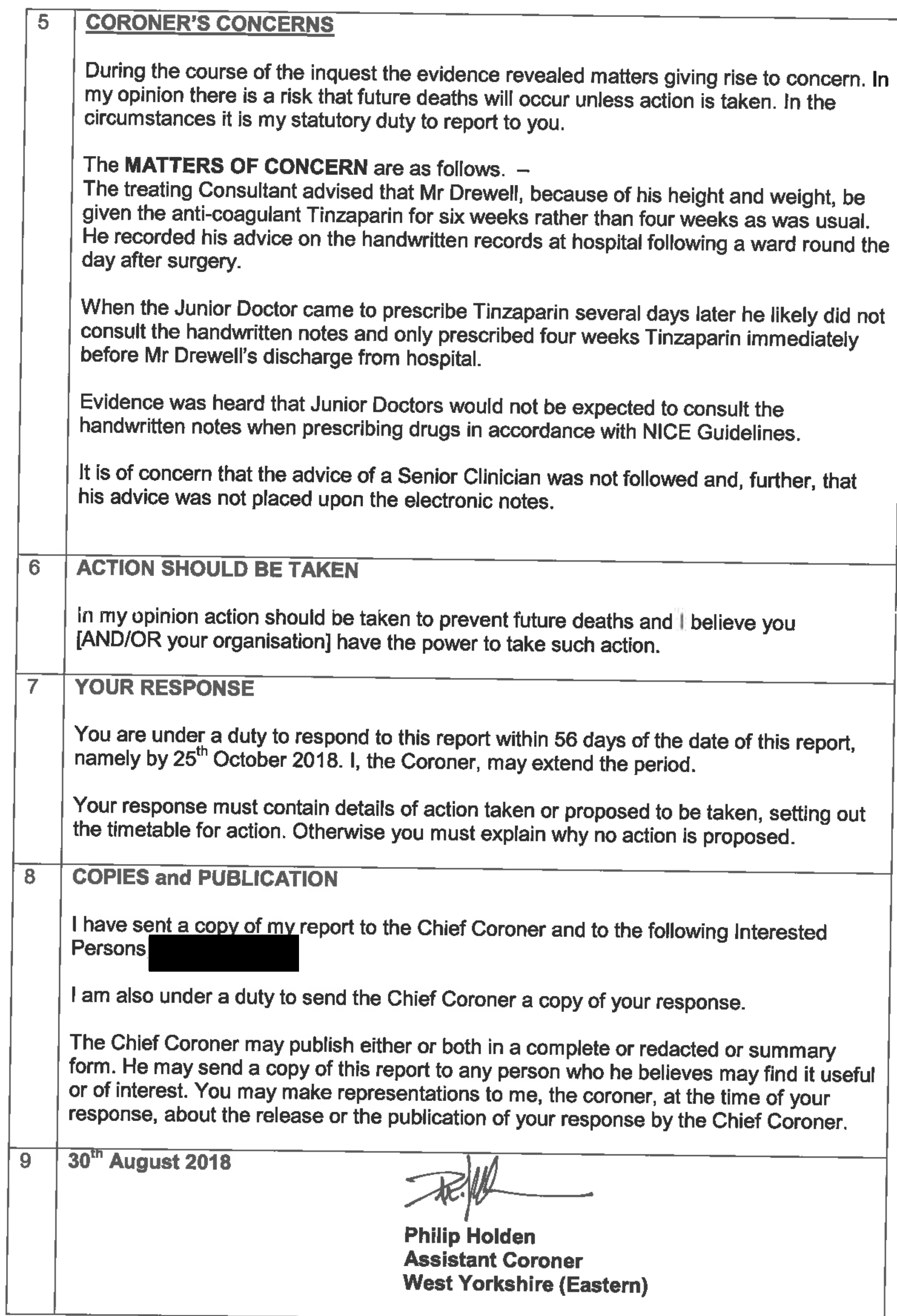
ANNEX A

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:** **Dr Yvette Oade, Chief Medical Officer, Leeds Teaching Hospitals NHS Trust, Trust Headquarters, Beckett Street, Leeds, LS9 7TF**
1	**CORONER** I am Philip Holden, Assistant Coroner, for the coroner area of West Yorkshire (Eastern)
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 3rd January 2018 I commenced an investigation into the death of Michael John Drewell, aged 57. The investigation concluded at the end of the inquest on 22nd August 2018. The conclusion of the inquest was that Mr Drewell died of a pulmonary thromboembolism.
4	**CIRCUMSTANCES OF THE DEATH** On the 16th November 2017 Mr Drewell fell of his bike whilst travelling to work. He attended at Leeds General Infirmary and was diagnosed with a displaced ultra capsular fracture of his right hip. He subsequently underwent surgery and his hip fracture was fixed with cannulated screws. On the 17th November 2017 his treating Consultant advised that he take Tinzaparin for six weeks to reduce the risk of Deep Vein Thrombosis. He was discharged from hospital on the 22nd November 2017 and was provided with a four week prescription for Tinzaparin. That prescription was given in accordance with National Guidelines but was not for the period of time, (ie six weeks), as advised by the Consultant. The prescription ended two days prior to his death. It is not possible to say whether the ending of the prescription more than minimally contributed to his death. On the 22nd December 2017 he suffered a cardiac arrest at home. Paramedics attended but were unable to resuscitate him. He was then taken to the Leeds General Infirmary and death was pronounced at 2355 hours that day. He died of a pulmonary thromboembolism which was likely a complication of his earlier hip surgery.



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 treating Consultant advised that Mr Drewell, because of his height and weight, be given the anti-coagulant Tinzaparin for six weeks rather than four weeks as was usual. He recorded his advice on the handwritten records at hospital following a ward round the day after surgery. When the Junior Doctor came to prescribe Tinzaparin several days later he likely did not consult the handwritten notes and only prescribed four weeks Tinzaparin immediately before Mr Drewell's discharge from hospital. Evidence was heard that Junior Doctors would not be expected to consult the handwritten notes when prescribing drugs in accordance with NICE Guidelines. It is of concern that the advice of a Senior Clinician was not followed and, further, that his advice was not placed upon the electronic notes.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 25th October 2018. 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 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	**30th August 2018** **Philip Holden** **Assistant Coroner** **West Yorkshire (Eastern)**