## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**Mr J. Adler, Chief Executive**<br>**University Hospitals of Leicester NHS Trust** |
| 1 | **CORONER**<br><br>I am Lydia Brown Assistant Coroner, for the area of Leicester City and Leicestershire South |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 3rd July 2018 I commenced an investigation into the death of Dorothy Joan Strickley<br><br>The Inquest concluded on 29th October 2018<br><br>Cause of death:<br><br>1a Pulmonary embolism<br>2 Laparoscopic appendectomy for appendicitis |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mrs Strickley underwent emergency surgery on 10th June 2018 for appendicitis. While in hospital she was provided with and wore anti embolic stockings. She was discharged home several days later, without surgical stockings which had been prescribed to her and were necessary to reduce the risk of venous thromboembolism.<br><br>The stockings were not physically provided, were not mentioned in the letter of discharge and were not referred to either in the Consultant's clinical notes or the discharge nursing entries. She became short of breath at home and died 19 days after surgery from massive pulmonary embolism. She was not made aware of any warning signs or symptoms that should have led to her seeking urgent medical attention.<br><br>The local Guidelines for Pharmacological and Mechanical Thromboprophylaxis for venous thromboembolism does not cover patient discharge from hospital, although the importance of continuing to wear anti embolic stockings (AES) after discharge until the normal daily activity levels are resumed is clearly set out in the NICE guidelines NG89. |
| 5 | **CORONER'S CONCERNS**<br><br>A basic and routine prescription for AES was not successfully brought to the patient's attention at the time of discharge and Mrs Strickley was unaware of the need to continue to wear stockings until she returned to her usual daily activity level. She died from the very complication that the stockings would have helped to prevent. |

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| | Various ways of communicating this to the patient were not utilized, such as the hospital discharge letter. There appeared from the evidence heard to be no standard literature or pamphlet providing patient discharge information.<br><br>There was a failure of both nursing and surgical teams to ensure AES were provided and the patient and/or her family were advised of the correct use.<br><br>Further training may therefore be considered necessary, together with a review of the documentation such as the nursing discharge tool.<br><br>The current local policy does not reflect NICE guidelines in full. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 2 January 2019 I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons.<br><br>[redacted]<br>Care Quality Commission<br>Healthcare Safety Investigation Branch<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **[DATE]**<br><br>**31/10/2018**<br><br>**[SIGNED BY CORONER]**<br><br>LYDIA BLAIN. |