REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, London North West University Healthcare NHS Trust**
1	**CORONER** I am Catherine Wood, assistant coroner, for the coroner area of West London.
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 15 February 2018 an investigation was commenced into the death of John Thorp, then aged 79. The investigation concluded at the end of the inquest on 15 February 2019. The conclusion of the inquest was natural causes, the medical cause of death being 1a) Pulmonary thromboembolism 1b) Deep vein thrombosis and 2) Right lower lobe pneumonia (recent treated Legionella pneumonia), Cardiomegaly.
4	**CIRCUMSTANCES OF THE DEATH** (1) Mr. Thorp became unwell in early January 2018 and was admitted to the Acute Medical Unit at Ealing Hospital on 9th January 2018 with a diagnosis of community acquired pneumonia. He was very unwell and underwent treatment with intravenous fluids, antibiotics and oxygen therapy. He was also commenced on Tinzaparin and prescribed TED (thrombo-embolic deterrent) stockings. (2) On the 10th January 2018 he deteriorated and was admitted to the Intensive care unit. He was ventilated and spent over two weeks in the Intensive Care Unit where he slowly improved and he was discharged to ward 6 North on 26 January 2018. (3) He deteriorated again on the 28 January 2018 with signs of a further chest infection which was treated appropriately with antibiotics and he went on to make a slow recovery, with his oxygen being weaned and a general improvement in his condition, such that plans for discharge were being made on 6 February 2018. (4) In the early hours of 8 February 2018 he deteriorated and became increasingly breathless. He was appropriately escalated and seen by a junior doctor who prescribed intravenous diuretics and ordered a chest x-ray. Before the latter could be performed Mr. Thorp suffered a cardiac arrest from which he could not be resuscitated and he died on the 8 February 2018.
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) Evidence given at the inquest by a senior nurse and Consultant indicated that only a doctor could prescribe TED stockings. There were three different prescriptions for TED stockings in the three different areas where Mr Thorp was treated. The standard ward based drug chart had a tick box in the low molecular weight heparin box on the drug chart for whether TED stockings were indicated.

	(2) Evidence was given at the inquest that the medical staff where inconsistent in how they prescribed TED stockings. One of Mr Thorp's drug charts had simply a tick in the box indicating there were required but there was nowhere for nursing staff to sign if they were given. Another drug chart had a separate prescription with the stockings being written up as a regular item and nurses could fill in the prescription chart to indicate if they had been given, or if not given the reasons why not. (3) There was evidence given that this inconsistency in the way in which medical staff prescribed the TED stockings may lead to stockings being prescribed but not given which may in turn increase the risk of thromboembolic formation.
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 23rd April 2019. 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 [redacted] Mr Thorp's daughter. 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	**26 February 2019** **[SIGNED BY Catherine Wood]** CWood