REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive, National Institute for Health & Care Excellence ("NICE"), 10 Spring Gardens, London SW1A 2BU
1	**CORONER** I am Peter Sigee, Assistant Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 15th January 2019 the Senior Coroner for the Coroner Area of Manchester North commenced an investigation into the death of Mrs Brenda McWilliams. The investigation concluded at the end of the inquest on 15th November 2019. The inquest determined that Mrs McWilliams died from natural causes, namely 1(a) Pulmonary Thromboembolism, 1(b) Deep Vein Thrombosis of the Leg Vein, 1(c) Poor Mobility, 2 Alzheimer's Disease.
4	**CIRCUMSTANCES OF DEATH** Mrs Brenda McWilliams died at the Royal Oldham Hospital on 3rd January 2019, aged 75 years. Mrs McWilliams had been diagnosed as suffering from Alzheimer's disease in October 2014. On 12th December 2018 Mrs McWilliams was unable to get out of bed, she was taken to hospital by ambulance and admitted; the hospital suspected that she may have developed delirium secondary to an infection. Mrs McWilliams remained immobile and she was assessed as being at high risk of venous thromboembolism (''VTE''). The hospital recognised that if a VTE developed then this was likely to be serious, even life-threatening. Whilst in hospital, Mrs McWilliams was given a daily injection of medication to minimise the risk of VTE. The hospital assessed Mrs McWilliams as fit for discharge to a residential care home on a short term basis while efforts were made to mobilise her. On 21st December 2018 Mrs McWilliams was discharged by the hospital and she moved to a residential care home. Mrs McWilliams remained immobile and the hospital recognised that: (1) at the time of discharge she remained at high risk of VTE; and (2) if this developed it was likely to be serious, even life-threatening. The hospital did not prescribe or recommend the use of medication to minimise the risk of VTE after discharge. Whilst in the care home, Mrs McWilliams remained immobile and her condition continued to deteriorate. Mrs McWilliams' GP prescribed antibiotics for a suspected infection but no treatment was given to minimise the risk of VTE at this time.

	On 2nd January 2019 Mrs McWilliams' physical condition deteriorated and she was admitted to hospital. Doctors considered that it was likely that Mrs McWilliams was suffering from sepsis and she was treated accordingly. Mrs McWilliams continued to deteriorate and she died on 3rd January 2019. Post mortem examination revealed that Mrs McWilliams had died from a pulmonary thromboembolism caused by a deep vein thrombosis of the leg vein which was caused by her immobility and that her death was contributed to by Alzheimer's disease. It is likely that the symptoms that the symptoms that were thought to be due to sepsis were in fact caused by the pulmonary thromboembolism.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion the 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:- I am concerned that the various medical practitioners who attended upon Mrs McWilliams did not cons continuing prescribing Mrs McWilliams medication to minimise the risk of VTE after her discharge from hospital on 21st December 2018 despite recognising that: (1) Mrs McWilliams remained at high risk of VTE and the consequence of such an event was likely to be serious, even life threatening; (2) it had been deemed appropriate to administer medication to Mrs McWilliams by means of daily injections whilst in hospital; and (3) there were no other suitable means identified and/or adopted to minimise this risk. I understand that NICE has published the following guidance: • Guideline NG89 ***"VTE in over 16s: reducing the risk of hospital-acquired deep vein thrombo or pulmonary embolism"*** • Quality Standard QS29 ***"VTE in adults: diagnosis and management"*** I was told that QS29 does not include recommendations for the prevention of VTE. The evidence that I heard suggested that medical practitioners have interpreted the NICE guidance as sa that it is not necessary/appropriate to prescribe medication to minimise the VTE risk for patients who a living in the community unless they have been discharged from hospital with short term immobility (for example with their leg in a cast following a fracture). Whilst I recognise that the decision to prescribe medication is a multi-factoral clinical decision I am concerned that the evidence I heard suggests that some patients living in the community who are at hig risk of VTE (who may not have been admitted to hospital whilst at high risk of VTE) are not being assess and treated with medication to minimise the risk of VTE, which if it develops can be a life-threatening condition.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 24th January 2020. 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 namely Mrs McWilliams' family and the Pennine Acute Hospitals NHS Trust. 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 from. 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: 29th November 2019 Signed: