ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Medical Director, LTHTR** **2. Chief Executive, LTHTR**
1	**CORONER** I am Miss Claire Hammond, Area Coroner for the coroner area of Preston and West Lancashire.
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 18 February 2015 I commenced an investigation into the death of Sharon Louise Henshall, 40 years of age. The investigation concluded at the end of the inquest on 10 August 2015. The conclusion of the inquest was that Sharon Louise Henshall died as a result of an unsurvivable pulmonary embolus, which was contributed to by a fractured ankle she sustained in a skiing accident in Italy on 9 February 2015.
4	**CIRCUMSTANCES OF THE DEATH** Sharon Louise Henshall was on holiday in Italy with her husband when, on 9 February 2015 whilst skiing, her ski got stuck in deep snow and as she tried to move she fell, pulling her right foot partially out of the boot. Although in pain, she did not seek medical treatment whilst on holiday in Italy, choosing instead to rest. She flew home to the UK on 16 February 2015 and attended Royal Preston Hospital where x-ray confirmed an undisplaced fracture of the medial malleolus, as a result of which she was placed in a below-knee plaster of Paris back slab and was referred to the fracture clinic for ongoing outpatient management. Her risk of Deep Vein Thrombosis ['DVT'] was not assessed, nor was she given prophylactic low molecular weight heparin ['LMWH']. The inquest heard evidence that at presentation on 16 February there were no signs or symptoms suggestive of a DVT being present at that time. The following evening, whilst at home with her husband, she suddenly collapsed and was taken to the Emergency Department at Royal Preston Hospital, where, despite advanced life support measures, she died in the early hours of 18 February 2015. The cause of death was 1a pulmonary embolus, 1b femoral vein thrombosis, 2 fractured ankle. The inquest found that for a pulmonary embolus to have developed on 17 February 2015, the initiating DVT must have been well-established by the time she was seen in the Emergency Department on 16 February, such that a prophylactic dose of LMWH given at that time would not have prevented the pulmonary embolus.

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 evidence of both [redacted] Consultant in Emergency Medicine, and [redacted] Consultant Physician, was that there is currently no venothromboembolism risk assessment model in place in the Emergency Department to assess the risk of VTE in patients discharged with lower limb immobilisation. The reason for this appeared to be that the evidence base regarding risk factors and success of prophylaxis is varied. [redacted] accepted that Sharon Louise Henshall should have been assessed. His evidence was that he and colleagues were working on developing a tool that would try to extrapolate data from the inpatient assessment tools to create an outpatient tool, but that it was difficult to know what benefit would be derived from giving prophylactic treatment. Dr McDowell's evidence was that creating a risk assessment tool would be a very easy thing to do, but that it would require a "major change in pathways," which would need to involve primary care to monitor complications. The **MATTERS OF CONCERN** are as follows. – (1) To have no assessment in place at all and to offer nothing in an area of known risks on the basis that the evidence base is varied, as opposed to having a tool in place, even one that recognises only the highest and obviously known/understood risk factors, seems unlikely to be adequate, and gives rise to a concern that future deaths will occur; (2) To have no interim tool in place pending the outcome of a 'major change in pathways' seems unlikely to be adequate; (3) Dr McDowell's evidence was that other European countries routinely give LMWH to patients with lower limb immobilisation, yet this is not something that is done at LTHTR, or uniformly across Trusts in England and Wales; (4) According to [redacted] the NICE guidance in this area, which was updated in June 2015, states that clinicians should have a discussion about risks and benefits with each individual, which necessarily requires having some form of tool or model in place to facilitate that discussion, yet there is no such tool in place within LTHTR; (5) The evidence of both [redacted] was that whether patients will be offered prophylaxis varies according to which hospital patients attend, since some Trusts offer it and some Trusts do not, and different Trusts have differing risk assessment tools taking different risk factors into account. It is of concern that due to the absence of national guidance there appears to be something of a 'postcode lottery' with regards to prophylaxis being offered or not.
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 15 October 2015. I, the area 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 Sharon Henshall's husband, John Henshall. I am also sending a copy of it to the Secretary of State for Health, the Chief Executive of NICE, Andrew Dillon, and Andrew Gwynne, MP for Denton and the Chair of the All Party Parliamentary Thrombosis Group. 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	**[DATE]** 20/8/15 **[SIGNED BY CORONER]**