REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive** **West Suffolk Hospital** **Hardwick Lane** **Bury St Edmunds** **Suffolk** **IP33 2QZ**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 25th April 2019 I commenced an investigation into the death of **Karen Jane Winn** The investigation concluded at the end of the inquest on 15th October 2020. The conclusion of the inquest was that:- **Karen 'Jane' Winn died as the result of the progression of a naturally occurring illness, contributed too by the non-administration of medication to prevent blood clots from forming. This medication had been earlier identified as being essential for her treatment and the non-administration of this essential medication amounts to neglect.** The medical cause of death was confirmed as: **1a Bilateral pulmonary embolism** **1b Deep venous thrombosis** **1c Haemolytic anaemia**
4	Karen 'Jane' Winn died on the 15th April 2019 at the West Suffolk Hospital, Bury St Edmunds in Suffolk. Jane had been admitted 4 days earlier on the 12th April 2019. On the 11th April 2019 Jane had visited her GP and had been diagnosed with a urinary tract infection and was prescribed antibiotics. She returned to her GP the next day and was described as being 'very unwell'. Her GP referred Jane straight to hospital. Once in hospital, on the evening of the 12th April 2019 a medical consultant gave Jane a differential diagnosis of haemolytic anaemia, a serious and uncommon blood disorder. It was identified that Jane had a risk of developing a Deep Vein Thrombosis (DVT) potentially leading to a pulmonary embolism. This is a known and life-threatening complication of haemolytic anaemia.

	At the time of diagnosis on the 12th April a decision was made that Jane should be placed on prophylactic anticoagulation medication, as soon as results from a repeat set of blood tests had been obtained. This repeat blood test (an INR test) was to ensure that any prophylactic anticoagulation medication would not increase Jane's risk of internal bleeding. Those blood test results became available later on the 12th April 2019, but at no time between then and the morning of the 15th April 2019 was prophylactic anticoagulation medication administered. Subsequently, an automated VTE (Venous Thromboembolism) risk assessment warning system, embedded into the electronic patient case record, was manually overridden 58 times during Jane's admission between the 12th and 15th April 2019. A single dose of prophylactic anticoagulation medication was administered one hour prior to Jane's death on the 15th April 2019, however this would not have been in a sufficient dose to breakup any blood clots that had already formed. Jane was taken to the Intensive Care Unit on the morning of the 15th April 2019 but suffered a cardiac arrest and died shortly after arriving there. A post-mortem examination confirmed widespread pulmonary emboli in Jane's lungs and significant blood clots (DVT's) in the veins in her upper legs. The fact that Jane had not received the anticoagulant medication that she needed directly contributed to her death.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters given 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** as follows. – 1. I am concerned that a differential diagnosis of a rare and serious blood condition (haemolytic anaemia), although identified soon after admission, was not escalated to a Haematology Consultant at the time this diagnosis was made. It was a rare condition, which by its very nature should be treated with the support of haematology specialists. I am concerned that those specialist were unaware that a differential diagnosis of serious blood disorder had been made without their specialist input. 2. In addition, I am concerned that the automated VTE assessment system does not appear to be significantly robust. I am aware that the WSH have taken steps to address the problem and have now placed the VTE assessment on the electronic Smart Zone 'to do list' and introduced an automated 14-hour consultant review function. However, I am concerned that as yet there is still no limit to the amount of times the automated 'pop-up' can be manually overridden and no automatic escalation process when it has been overridden a certain number of times. 3. I am further concerned that if a consultant at an early review has decided that prophylactic anticoagulation medication needs to be administered (even in the situation when a INR test is still awaited) that this is not clearly flagged on the patient electronic record in the Smart Zone, to act as a prompt for clinicians taking over that patients care.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17th December 2020 I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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;- 1. Mrs Winn's family. I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**22nd October 2020** **Nigel Parsley**