Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 NHS Quality, Safety & Investigations

1 CORONER

I am Professor Catherine Mason, Senior Coroner for the area of Leicester City and South Leicestershire

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 Seventh November 2018 I commenced an investigation into the death of Cherry Rosemary Dunn aged 68. The investigation concluded at the end of the inquest on Nineteenth August 2021. The conclusion of the inquest was:

Natural causes

The cause of death was established as:

I a Pulmonary Embolism

I b Deep Vein Thrombosis

I c Immobility

II Depressive illness and falls

4 CIRCUMSTANCES OF THE DEATH

Mrs. Dunn was admitted to the Leicester Royal Infirmary (LRI) following a fall and urinary retention with a change in behaviour on the 3rd October 2018. She was referred to the Frail Older Person's Advisory Liaison (FOPALS) service, based at the LRI on the 5th October 2018, for a further mental health assessment. She was subsequently transferred to the Kirby Ward at the Bennion Centre (Leicestershire Partnership Trust) late at night on the 24th October 2018 under a Section 2

of the Mental Health Act for further assessment. While an inpatient at the LRI, Mrs. Dunn was prescribed prophylactic anticoagulation. This was not continued on discharge on the understanding that upon transfer to another unit a DVT assessment would be completed at the point of admission.

The following day Mrs. Dunn suffered a fall and was transferred to the Emergency Department and subsequently the Emergency Frailty Unit (EFU) at the LRI. She was transferred back to Kirby Ward on the 26th October 2018.

Following Mrs. Dunn's initial admission to the LRI at the beginning of October, and subsequently whilst an inpatient in Kirby Ward, she was noted to have bilateral swollen legs. In Kirby Ward, Mrs. Dunn's swollen legs were reviewed a number of times by junior doctors. Mrs. Dunn had a positive Venous Thromboembolism (VTE) assessment on admission on the 24th October 2018. This was based on her limited mobility. Mrs. Dunn had a further VTE assessment on the 30th October 2018 which was negative.

Mrs. Dunn suffered an acute episode on the 5th November 2018 and despite resuscitation attempts, she died at 14:07 hours.

Jury findings as per part 3 of the Record of Inquest
Cherry Rosemary Dunn met her death at Kirby Ward, The Bennion Centre, Groby Road, Leicester LE3 9DZ on the 5th of November 2018, whilst detained under Section 2 of the Mental Health Act 1983.
On the balance of probabilities it is more likely than not that the incomplete, inaccurate and insufficient records/verbal information communicated between healthcare professionals on Kirby Ward as well as Mrs Dunn's lack of engagement due to her mental health, contributed to her death from a pulmonary embolism. This prevented proper investigation to be made. This includes information about her fluid intake and dietary intake, and her mobility.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

- Clinical indications of VTE
  Bilateral leg swelling overshadowed the consideration for a DVT and without guidance to all doctors nationally, bilateral leg swelling will remain a problem for the diagnostic profiling of a DVT.
- VTE risk assessment form
  The VTE risk assessment used at the time of Mrs Dunn's death was not as comprehensive as it could have been. Leicestershire Partnership NHS Trust have made improvements to their original form (previous and current ones attached to this report). However, a concern remains that it is still not as clear as it could be, and different conclusions could be arrived at depending on the doctor completing the form. This would then impact on whether prophylactic anticoagulation is prescribed. Therefore, there is a concern that this is a problem nationally and different hospitals use different VTE risk assessments that can be confusing.
- Hospital discharge letters
  The discharge letter used when Mrs Dunn was transferred from one hospital setting to another (attached) was confusing. The doctor at the receiving hospital read it to mean that prophylactic anticoagulation was not required and therefore the doctor was

persuaded in part by this even though the risk assessment that was completed had a positive result.
The University Hospitals of Leicester NHS Trust have now revised their discharge letter (attached) which more clearly reflects NICE Guidance and removes the previous confusion.
However, there is a concern that the original discharge letter is used in other Trusts and therefore the confusion remains in other areas with the risk of what happened in this case happening elsewhere.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 21 October 2021. 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], University Hospitals of Leicester NHS Trust, Leicestershire Partnership NHS Trust, [redacted], [redacted] and [redacted]. I have also sent it to the Care Quality Commission.

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.

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Professor Catherine E. Mason
H.M. Senior Coroner
Leicester City & South Leicestershire

Honorary Professor
East Midlands Forensic Pathology Unit
(Leicester Cancer Research Unit)

[redacted]

Dated: 26 August 2021