Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive Norfolk & Suffolk NHS Foundation Trust Hellesdon Hospital Drayton High Road Hellesdon Norwich NR6 5BE
1	**CORONER** I am Yvonne Blake Area Coroner for the coroner area of Norfolk
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 15th November 2019 I commenced an investigation into the death of Sheila Elizabeth STEGGLES aged 72. The investigation concluded at the end of the inquest on 4th February 2022. The cause of death was 1a) Acute Pulmonary Embolus (PE) 1b) Deep Vein Thrombosis (DVT) The conclusion from the jury was Natural Causes. There were a number of collective failings and missed opportunities that may have contributed to Shelia Steggles' death. 1) There was no written Venous Thrombus Embolism (VTE) assessment for Sheila Steggles after July 2019. 2) Insufficient consideration was given to Sheila Steggles' reduced mobility because of diagnostic overshadowing. 3) The clinical notes failed to highlight Sheila Steggles' past medical history of Deep Vein Thrombosis (DVT) and associated risks. 4) There was inadequate DVT training for ward staff. 5) Administering a prophylactic dose of heparin may have resulted in a different outcome.
4	**CIRCUMSTANCES OF THE DEATH** Sheila Steggles was admitted twice under section of the Mental Health Act in 2019. She had a diagnosis of Bi-polar Affective Disorder and suffered from depression and anxiety together with Hypothyroidism and 2 previous DVT's. She had Chronic Lymphoedema to both legs. In October 2019 Sheila Steggles was transferred to a rehabilitation ward to ready her for discharge to supported housing prior to going to her home, as it was felt that her

	presentation and mental health had improved. She was usually independently mobile but on 25th and 26th October 2019 she requested a wheelchair and one was brought in from home. She used this to push and walk about the ward. By 31st October 2019 when Sheila Steggles complained of feeling unwell her mobility had declined and she was not coming out of her room. There was no evidence that she was walking then except briefly when seen by a doctor. No specific illness was detected although physical observation and blood tests were done, these were all normal. The same doctor saw her on 1st November 2019 again nothing specific was found. On both occasions Shelia Steggles was examined for a current DVT but no documented formal assessment of her future risk of DVT was made. She had several risk factors, she was over 60, obese and had a past history of DVT. Her reducing mobility was not considered a further risk factor even though it put her into the very high category because it was thought to be due to her mental health and may therefore improve. After the 1st November 2019 the doctor went on leave and left instruction that any further concerns be raised and if needed a doctor would review. Sheila Steggles was not reviewed on 2nd November 2019 and remained on her bed in her room and on 3rd November 2019 another doctor reviewed her, again looking for current DVT but finding none and no consideration was given to her future risk given that her mobility was greatly reduced. On 4th November 2019 a doctor was called for general not specific concerns and he chose not to examine Shelia Steggles since on the notes her presentation had not changed from 3rd November 2019. On the morning of 5th November Sheila Steggles collapsed whilst being moved and suffered a cardiac arrest. Resuscitation was prompt and emergency services attended but she died in the ambulance. An expert opinion concluded that on the balance of probabilities the DVT was not formed before the 2nd November 2019 and that prophylaxis given then would have prevented the DVT and the PE.
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: Irrespective of the reason for a person's mobility reducing, if it does so and this is a known risk factor then notice must be taken of it and appropriate steps taken. Medical staff should follow the Trust's protocols and perform and document a VTE risk assessment when the reduction in mobility is reduced (from their baseline) even if it is not known if/ how long the reduction will continue. All staff should raise concerns and if they have specific ones, document what these are in the clinical notes. Clinical notes should contain more detail about the patient since they are what is relied upon (with a verbal handover) to inform staff on later shifts. If a patient is to be reviewed then a specific plan should be placed on to the care plan so that everyone knows what is needed to be done. All staff should be aware of a patient's relevant past medical history. Junior staff should consult more senior staff if they are unsure of the effect that anti-coagulation will have on anti-psychotics or other medication and are thus concerned about administering this.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 April 04, 2022. 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] (family of Sheila Steggles) G.T. Stewart – Solicitors for family [redacted] – Counsel for family and Department of Health Care Quality Commission HSIB Healthwatch Norfolk who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 10/02/2022** **Yvonne BLAKE** **Area Coroner for** **Norfolk**