David Ridley
HM Senior Coroner
for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Kevin McNamara Esq. Chief Executive Officer The Great Western Hospital NHS Foundation Trust Marlborough Road Swindon SN3 6BB7
1	**CORONER** I am David Ridley, Senior Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 21 January 2020 I commenced an investigation into the death of Winifred Mary Redfearn, otherwise known as Mary Redfearn and I then went onto open her Inquest on the 24 January 2020. On 19 June 2020 I concluded Mary's Inquest finding that the medical cause of death was:- **1a) Pulmonary thromboembolism** **b) Deep vein thrombosis** **c) Immobility due to head and neck injuries due to fall** **2) Ischaemic heart disease** I recorded how, when and where Mary came by her death as follows: - *Winifred who was known by her middle name Mary died on the morning of 15 January 2020 at the Great Western Hospital in Swindon. A post mortem revealed that she died from a pulmonary embolism caused by a deep vein thrombosis attributable to her immobility in hospital after she was admitted to hospital following a fall down the stairs at home on 8 January 2020. As a result of the fall she injured her head and neck. Mary also had ischaemic heart disease which more likely than not contributed to her death.* CONCLUSION - **Accident**
4.	**CIRCUMSTANCES OF DEATH** I was satisfied on a balance of probabilities that the incident resulting in Mary's attendance at the Great Western Hospital occurred when she fell down the stairs at her home on Wednesday 8 January 2020. She attended the emergency department at the Great Western Hospital on Thursday 9 January 2020 at 2323 hours and was admitted the following day. As part of the evidence I had a statement from Locum Senior House Officer, [redacted] and noted that

	mid-afternoon on 10 January 2020 as a result of a planned CT scan of the whole body the decision was taken to withhold venous thromboembolism prophylaxis. The CT scan was completed and reported the same day at 1922 in respect of which the injury, in particular to her spine at C6, C7 was revealed. The Pathologist, [redacted] found at post mortem that the cause of Mary's death was as a result of developing a deep vein thrombosis as a result of immobility which then led to the development of pulmonary thromboembolism from which she died. Having reviewed [redacted] statement, I noted that despite the involvement of 3 other doctors on the evening of the 10 January 2020 that it was not until the afternoon on Monday 13 January 2020 was a request made to resume Dalteparin as part of the venous thromboembolism prophylaxis.
5.	**CORONER'S CONCERNS** I had no evidence before me to say more likely than not that it would have made a difference and having dealt with many cases similar to this, I fully recognise that even with venous thromboembolism prophylaxis, the risk of developing a deep vein thrombosis and subsequent pulmonary thromboembolism can never be completely excluded. That having been said I am, however, somewhat concerned that the resumption of Dalteparin took in excess of 2½ days from the production of the CT report and the delay would appear to be solely attributable to the weekend separating the point of which the Dalteparin was stopped and when it was resumed on Monday afternoon. Whilst I accept it may not have made a difference in this particular case, I am concerned that in other cases that such a delay could result in the unnecessary premature death of a patient which is why I am raising this concern.
6.	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 August 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.
7.	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Person, [redacted] 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.
8.	Dated 25 June 2020 Signature [signature] David Ridley, Senior Coroner for Wiltshire & Swindon