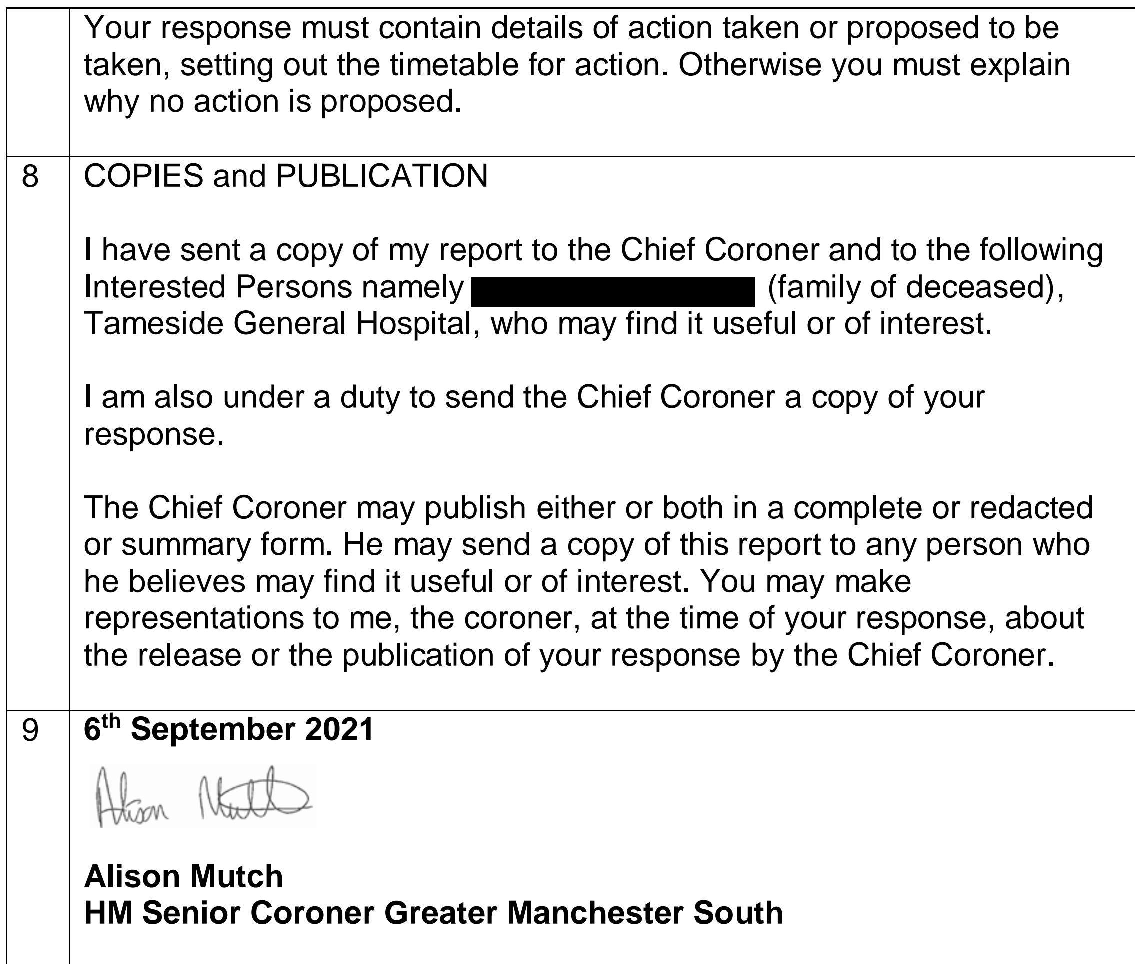
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **NHS England and Secretary of State of Health and Social Care**
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 3rd March 2021 I commenced an investigation into the death of Mark Holden. The investigation concluded on the 24th August 2021 and the conclusion was one of Narrative: Died from the complications of a deep vein thrombosis not diagnosed until after death and that was probably present on 19th February 2021 and on 23rd February 2021 when medical advice was sought. The medical cause of death was 1a Pulmonary Embolus 1b Deep Vein Thrombosis, II Covid -19 Pneumonia
4	CIRCUMSTANCES OF THE DEATH Mark Thomas Holden was diagnosed with Covid-19 on 18th February 2021 having had symptoms for a few days previously. He attended the Emergency Department at Tameside General Hospital. His D-Dimer was 1505. He was discharged home with advice to return if he deteriorated. On 19th February 2021, he returned to Emergency Department at Tameside General Hospital concerned that he had a deep vein thrombosis in his left leg. His D-Dimer was over 10,000. The treating clinician did not see the report for reasons that were unclear. He was referred for a doppler scan. The scan looked at the superficial femoral junction and not the calf. Under NICE guidance a follow up appointment should have been made given the raised D-Dimer. One was not made. The discharge summary did not contain the D-Dimer reading. He was not given anticoagulants. On 23rd he contacted his GP still feeling unwell. A telephone appointment was conducted. The GP was unaware he had a raised D-Dimer.

	Amoxicillin was prescribed for a persistent cough. No face to face examination took place. A DVT was not considered. On 26th February 2021, he collapsed at home. He was taken to Tameside General Hospital where attempts to resuscitate him were unsuccessful. Post-mortem examination found that he had a deep vein thrombosis in his left calf that had been there for about 7-10 days and that had led to a 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 MATTERS OF CONCERN are as follows. – 1. The appointment with the GP was via telephone due to Covid. As a result, there was no examination of Mr Holden and no opportunity to identify the DVT which was present at the time of the telephone consultation. 2. The D-Dimmer of over 10,000 did not trigger an alert on the Lorenzo electronic system due to how it was reported and the configuration of Lorenzo at that time at the Trust. The Trust have taken steps to change how the reports are input into Lorenzo to ensure a raised D- Dimmer such as this triggers an alert. It was unclear if that learning has been shared across the NHS to other trusts who use Lorenzo to ensure that alerts are triggered. 3. The inquest heard that there will often be a raised D- Dimmer with Covid-19 and that in addition that there is an increased risk of clots with Covid-19. The evidence before the inquest was that the existing NICE guidance used by clinicians does not deal with the Covid-19 aspects/ recognised risks.
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 1st November 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 namely (family of deceased), Tameside General Hospital, who may find it useful or of interest. 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	**6th September 2021** **Alison Mutch** **HM Senior Coroner Greater Manchester South**