H G Mark Bricknell
Senior Coroner
for County of Herefordshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, Wye Valley NHS Trust.
1	**CORONER** I am Hugh Gregory Mark Bricknell, Senior Coroner for County of Herefordshire.
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 13 October 2021 I commenced an investigation into the death of Alison June Dallow. The investigation concluded at the end of the inquest on 20 July 2022. The conclusion of the inquest was the following Narrative: Mrs Dallow fractured her Left Tibial Plateau following a fall. A brace reduced her mobility as did the fracture. She was not prescribed prophylaxis. Mrs Dallow died from the medical causes given. Mrs Dallow was diagnosed with Covid 19 shortly before her death.
4	**CIRCUMSTANCES OF THE DEATH** Alison June Dallow died from a Pulmonary Thromboembolism due to Deep Vein Thrombosis. She had restricted mobility following a fracture and fitting of a knee brace.
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) It was unclear whether the clinical advice was to 'toe touch' or stay non- weight bearing. (2) The current hospital policy in connection with reducing the risk of Venous Thromboembolism was unclear especially regarding outpatients who apparently account for the majority of fractures treated. (3) Evidence of any information given to the patient was unavailable at the Inquest.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, [redacted] 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 28 September 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. 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	3 August 2022 Signature_____ HG Mark Bricknell, HM Senior Coroner: Herefordshire