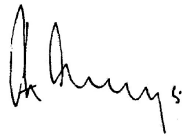
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1** [redacted]
1	**CORONER** I am Sean CUMMINGS, Assistant Coroner for the coroner area of Bedfordshire and Luton Coroner Service
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 05 December 2019 I commenced an investigation into the death of Hollie Anne RICHARDSON aged 26. The investigation concluded at the end of the inquest on 27 April 2022. The conclusion of the inquest was that: Hollie Anne Richardson died at the Luton and Dunstable Hospital on the 27th November 2019. She was 26 at the time of her death. She had been diagnosed as suffering from protein S deficiency, an inherited blood disorder predisposing to blood clots. She was heterozygous for the gene. There was a very strong family history of firstly other members being affected by protein S deficiency and secondly some of those family members suffering from blood clots, some fatal, as a result. She was not anti-coagulated prophylactically. She was admitted to the Luton and Dunstable Hospital very poorly on the 14th November 2019. While there she suffered a cardiac arrest secondary to a massive pulmonary embolism. She was resuscitated and the transferred to Papworth Hospital for ECMO. She was returned for ongoing care to the Luton and Dunstable Hospital where she later died.
4	**CIRCUMSTANCES OF THE DEATH**
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) I heard expert evidence during the course of the Inquest relating to the management (or lack of) following Hollie's diagnosis of being heterozygous for Protein S deficiency. My expert told me in written evidence that "There was no indication for Hollie to be reviewed periodically as the advice not to receive anticoagulant medication would not have changed unless she had a thrombotic event. If she had a thrombosis then she should have been reviewed by a haematologist to consider long term anticoagulation". The difficulty with this is that the expert acknowledged that other life events may alter the risk of

	thromboembolism. In Hollie's case, there was a very strong family history of protein S deficiency and of some of those suffering from blood clots including fatalities. In addition, Hollie was considerably overweight and seemingly was unaware of the increased burden of thromboembolic events this conferred on her. Counsel for Hollie's family, correctly in my view, pointed to a lacuna in the management of protein S deficiency where patients were given the diagnosis but had no reasonable knowledge of what might exacerbate the risk (because they are not told or under surveillance) so they were blind to actions that they may take to mitigate the risk. That places the responsibility for management of other risk factors squarely with the patient, who might well be ignorant of them, rendering such a position potentially hazardous.
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 December 01, 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] I have also sent it to 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: 06/10/2022**  **Sean CUMMINGS** **Assistant Coroner for** **Bedfordshire and Luton Coroner Service**