REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: NHS England and NICE (National Institute for Health and Care Excellence)
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 August 2022 I commenced an investigation into the death of Rebekah Juliet Mills. The investigation concluded on the 6th February 2023 and the conclusion was one of **Narrative: Died from post-operative complications of surgery following an accidental fall resulting in injury.** The medical cause of death was **1a) Pulmonary Embolus; 1b) Post Meniscus Repair**
4	CIRCUMSTANCES OF THE DEATH Rebekah Juliet Mills had an accidental fall when skiing and she hurt her knee. She went to Stepping Hill Hospital and was seen in the Emergency Department. An examination identified no obvious injury. The notes did not capture her being on oral contraceptive or the degree of her lack of mobility. The virtual fracture clinic review on 13th June 2022 referred her to the physiotherapy team for an appointment. Backlogs meant this did not take place as envisaged. On 22nd June she sought further help. She was seen on 11th July and a scan on 13th July identified a significant knee injury that had caused her knee to lock. She was seen on 21st July, and it was identified as repairable with surgery, but the surgery was urgently required. She was asked to stop taking oral contraceptive (a risk factor for surgery) which she did. On 28th July 2022 she was operated on. She was discharged home. On 1st August 2022 she collapsed and was taken to Stepping Hill Hospital where she died from a pulmonary embolism.
5	<u>CORONER'S CONCERNS</u> 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. – During the course of the inquest evidence was given that the guidance for clinicians in relation to reducing the risk of DVT when dealing with patients such as Ms Mills who are young and on oral contraception but are immobile following an accident and require surgery is unclear. That lack of clarity can give rise to a differing approach and a lack of recognition of the potentially fatal risk that patients such as Ms Mills can face in such a situation. The evidence was that greater clarity and greater understanding of the risks could prevent future deaths.
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 10th July 2023. 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 1) [redacted] on behalf of the Family, and; 2) Stockport NHS Foundation Trust, 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	**Alison Mutch** **HM Senior Coroner**  **15.05.2023**