REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chesterfield Royal Hospital NHS Foundation Trust**
1	**CORONER** I am Matthew Kewley, Assistant Coroner for Derby and Derbyshire.
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 5 October 2021 I commenced an investigation into the death of Jessica Hodgkinson ("Jess"). The investigation concluded at the end of the inquest on 27 January 2023. The narrative conclusion of the inquest was: *'Jess died on 14 May 2021 due to a pulmonary embolism that arose from a deep vein thrombosis (the risk of this was increased by the KTS) as well as acute anaphylaxis of unknown cause. There was a failure to ensure that Jess received anticoagulant medication that a clinician had intended should be taken until birth. This failure made a more than minimal, negligible or trivial contribution to Jess' death on 14 May 2021.'*
4	**CIRCUMSTANCES OF THE DEATH** Jess was born on 9 August 1994. Jess died on 14 May 2021 at the Chesterfield Royal Hospital shortly after giving birth to her daughter. Jess had a high risk pregnancy. This was primarily due to Jess' severe hypertension. Jess also had a rare condition known as Klippel-Trenaunay Syndrome ("KTS") which created an increased risk of Jess developing a deep vein thrombosis/pulmonary embolism. The main challenge during Jess' pregnancy was her hypertension. The inquest found, however, that Jess' hypertension was managed appropriately by her consultant in Chesterfield with input from a specialist renal physician. As to KTS, the inquest found that there was no documented evidence of clinicians in Chesterfield having properly considered the impact that KTS may have on Jess' pregnancy. The inquest found that this did not, however, contribute to Jess' death. On 21 April 2021 a consultant in Chesterfield prescribed a prophylactic dose of tinzaparin due to an increased risk of clotting. The consultant gave evidence at the inquest that the intention was for Jess to continue to receive a daily dose of anticoagulant medication up until birth. Jess was then transferred to a hospital in Sheffield on 22 April 2021. There was a failure to communicate to the hospital in Sheffield the plan for ongoing prophylactic anticoagulant medication to continue until birth. This meant that the team in Sheffield were unaware of the plan for prophylactic anticoagulant medication to continue until birth. Jess was discharged from the hospital in Sheffield on 26 April 2021 back into the care of the team in Chesterfield without any anticoagulant medication. During the subsequent weeks following the discharge from Sheffield, clinicians in

	Chesterfield failed to identify that Jess was no longer receiving the anticoagulant medication that Jess' consultant in Chesterfield had intended would be taken until birth. A clinician gave evidence at the inquest that she would have restarted the tinzaparin had she been aware that Jess was no longer receiving it upon her discharge from Sheffield. The inquest found that if Jess had received the daily anticoagulant medication as the clinician in Chesterfield had intended, it is more likely than not that the pulmonary embolism would not have occurred. Therefore, the failure to ensure that Jess received the intended anticoagulant medication up until birth made a more than minimal, negligible or trivial contribution to her death on 14 May 2021. On 13 May 2021 Jess attended the Chesterfield Royal Hospital and a decision was made to carry out an emergency caesarean section. The procedure was successful and Jess' baby was born. Shortly after delivery, Jess went into cardiac arrest. Despite the very best efforts of the attending clinicians, Jess died on 14 May 2021. A post mortem examination took place. The cause of death was a pulmonary embolism that arose due to a deep vein thrombosis (the risk of this was increased by the KTS). Jess also died as a result of an acute anaphylaxis. It was not possible to identify the cause of the anaphylaxis but the inquest heard evidence that it could have been caused by an antibiotic despite Jess having no known allergies. The inquest found that the efforts of those involved in the resuscitation were exemplary.
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 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. – (1) I heard evidence from Jess' consultant that she intended that tinzaparin would be taken by Jess up until birth. When Jess was discharged from Sheffield back into the care of Chesterfield, nobody in Chesterfield identified that Jess was not receiving the tinzaparin which the consultant told the inquest ought to have been in place until birth. (2) I heard evidence that there was no communication to the team in Sheffield that Jess' consultant in Chesterfield intended that she should continue to receive tinzaparin until birth. Therefore, when Jess was discharged from Sheffield on 26 April 2021, she was not given tinzaparin because the team in Sheffield were unaware of this plan. I am concerned, therefore, about the quality and adequacy of the information handed over to Sheffield at the point of Jess being transferred into their care. (3) I heard evidence that following Jess' discharge from Sheffield on 26 April 2021, Chesterfield did not receive any communications from Sheffield about Jess' care during her time in Sheffield. I am concerned that there was no process in place in Chesterfield to follow up and find out what had happened during Jess' short period under the care of Sheffield. Had efforts been made to liaise with the team in Sheffield, the tinzaparin issue might have been identified. (4) I heard in evidence that some staff were unaware of KTS and its potential implications for pregnancy. This was understandable. However, I did not see evidence of any consultant having properly considered and then documented in Jess' notes the potential impact that KTS might have had on Jess' pregnancy.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 21 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 Jessica's family. 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	**26 May 2023** **M. Kewley**