MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Group Chief Executive of Barts Health NHS Trust
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East London
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 16 February 2023 I commenced an investigation into the death of Mr John Michael James. The investigation concluded at the end of the inquest on the 6 July 2023. The conclusion of the inquest was a narrative conclusion: *Mr. James died as a result of a pulmonary embolism during the course of a lengthy hospital admission. He was at very high risk of developing a venous thromboembolism. There were three missed doses of anti-coagulation medication in the two weeks leading up to his death.*
4	**CIRCUMSTANCES OF THE DEATH**

	Mr. James was admitted to Whipps Cross Hospital on the 13 October 2022 and was found to be suffering from malnutrition and a bowel obstruction (later discovered to be due to an adenocarcinoma). He underwent surgery on 18 October 2022 to remove the tumour. This was surgically uneventful. Post-operatively, he required a lengthy period of intensive care. On the 19 December 2022 he was stepped down from intensive care to a ward. He was at a very high risk of developing a thromboembolism due to his cancer diagnosis, recent surgery, lengthy period in hospital and immobility. During the period of 9 to 15 January 2023 he refused his anti-coagulation medication on three occasions. The reason for refusal is unclear and there is no documented evidence that the risk of non-compliance with the medication was explained to him or escalated to the medical team. On the 20 January 2023, Mr. James suffered from an acute deterioration in his health, culminating in a cardiac arrest. He passed away at Whipps Cross Hospital on the 21 January 2023 from a pulmonary embolism. The missing doses of anticoagulation during the two weeks leading up to his death is likely to have contributed to a degree, to the development of the pulmonary embolism.
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: The refusal of anti-coagulation medication was not brought to the attention of medical staff. The administration of anti-coagulation medication to patients like Mr James, is vital for reducing the risk of a venous thrombo-embolism, a potentially life-threatening condition. There is no electronic prompt/alert to highlight to the medical team when prescribed anticoagulation medication is not administered. The Trust's internal investigator recognised that a fail-safe should be put in place within the electronic records, to ensure escalation to the medical team where doses of prescribed anti-coagulation are not administered. Such a measure could prevent similar deaths from occurring. It was considered that this measure could assist in preventing future deaths not just locally, but at a wider level.
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 **6 September 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 family of Mr James. I have also sent a copy to the local Director of Public Health who may find it useful or of interest and to the CQC. 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 other 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.
9	**11 July 2023**