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] – Chief Executive University Hospitals Sussex NHS Foundation Trust**
1	**CORONER** I am Joanne ANDREWS, Area Coroner for the coroner area of West Sussex, Brighton and Hove
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 13 April 2022 I commenced an investigation into the death of Ann Dorothy PEARCE aged 61. The investigation concluded at the end of the inquest on 27 November 2023. The conclusion of the inquest was a narrative which stated: Ann Dorothy Pearce sustained a fracture of her tibial spine on 26 March 2022 having fallen from her bicycle in Burgess Hill that day. She was taken to the Princess Royal Hospital for treatment and discharged on 28 March 2022. On 1 April 2022 she became unwell at home and an ambulance attended and took her to the Princess Royal Hospital for treatment where she was diagnosed with a massive pulmonary embolism. She was treated but sadly died on 1 April 2022.
4	**CIRCUMSTANCES OF THE DEATH** Ann Dorothy Pearce was taken to the Princess Royal Hospital for treatment and was discharged on 28 March 2022. During her admission she was immobilised in a brace and on discharge was only partially weight bearing. The Venous Thromboembolism Prevention Policy of University Hospitals Sussex NHS Foundation Trust version 1.4 required that this should be undertaken on admission and reviewed on the daily ward round. No Venous Thromboembolism assessment was undertaken during her admission or on discharge. She became unwell at home on 1 April 2022 and was taken to hospital for treatment but sadly died from a massive pulmonary embolism

	that day.
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: Evidence at the inquest revealed that the Venous Thromboembolism Prevention Policy of University Hospitals Sussex NHS Foundation Trust version 1.4 did not make provision for assessment of risk to patients who attended hospital but were not admitted. There was no evidence of any other policy or procedure which did so.
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 January 23, 2024. 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 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: 28/11/2023** J. Andrews **Joanne ANDREWS** **Area Coroner for** **West Sussex, Brighton and Hove**