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:** **University Hospitals of Leicester NHS Trust and NHS England**
1	**CORONER** I am Mrs D HOCKING, His Majesty's Assistant Coroner for the coroner area of Leicester City and South Leicestershire
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 30 January 2023 I commenced an investigation into the death of Patricia Ann WALTON aged 80. The investigation concluded at the end of the inquest on 28 November 2023. The conclusion of the inquest was: 'Accidental death contributed to by natural causes and an error in the administration of her dual anticoagulation which led to a haemorrhage into her chest and abdominal wall.' The cause of death was established as: I a Bilateral Pneumonia I b Immobility due to Fractured Right Fibula, Chronic Obstructive Pulmonary Disease and Anaemia secondry to Right Chest and Abdominal Wall Haematoma II Diabetes Mellitus Type 2, Severe Coronary Artery Atherosclerosis, Obesity, Hyperlipidaemia, Old Age and Frailty
4	CIRCUMSTANCES OF THE DEATH Mrs Walton had a fall at her grand-daughter's address whilst she was visiting on Christmas Day 2022. Initially it was thought that she was not badly injured, but her immobility developed leading to an ambulance being called on the 28 December 2022. There was a delay in the ambulance arriving but when it did, she was conveyed to the Leicester Royal infirmary on the 29 December 2022. She was diagnosed with a fractured right ankle and shoulder injury. A boot was put on her right leg for conservative treatment of the fracture, and she was admitted. A doctor reviewed her on the 30 December 2022 and noted that she was taking warfarin to treat atrial fibrillation and decided to put her on dalteparin as they considered her International Normalized Ratio (INR) was too low. No plan was made at that time as to when to review the situation or when to stop the dalteparin. She was not seen by

	a Consultant Medical Physician until the 03 January 2023. He did not appreciate that she was taking warfarin and dalteparin. The INR was being measured but not considered or reviewed and by the 02 January 2023 it was above 2 which should have initiated stopping the dalteparin. However, it was not stopped at that time. Mrs Walton's haemoglobin suddenly dropped on the 04 January 2023. On the 05 January 2023 the medical staff noticed that she was on dual anticoagulation therapy and the dalteparin was stopped and Vitamin K and blood was given. She was commenced on antibiotics for a chest infection and taken to radiology for a pelvic x-ray as it was thought that a pelvic fracture may be the source of the blood loss. It was thought that the x-ray showed a fractured pelvis, but this was later confirmed not to be the case. Further investigations were not undertaken to confirm a fracture as Mrs Walton's condition deteriorated in the radiology department. She returned to the ward and was treated for pneumonia with antibiotics. Sadly, her condition continued to deteriorate, and she was taken off medications. She died at Leicester General Hospital on the 09 January 2023.
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: The evidence at the inquest was that no medical practitioner saw this lady from the 30 December 2022 to the 03 January 2023, over the New Year Bank Holiday period. My concerns are that whilst there might be a doctor available on call to treat emergencies that occur, there is insufficient cover to assess the subtleties of care required by patients, the absence of which may be as detrimental to the patient as not having emergency cover.
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 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] (daughter) on behalf of the family of Mrs Walton I have also sent it to the Care Quality Commission 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: 05/12/2023**  **Mrs D HOCKING** **His Majesty's Assistant Coroner for Leicester City and South Leicestershire**